Theories of Justice and an HIV/AIDS Health Care Policy for South Africa : A Comparative Analysis.

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I, the undersigned, Lynette Margaret Horn, hereby declare that the work contained in this assignment is my own original work and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Abstract :

Theories of justice and an HIV/AIDS health care policy for South Africa : a comparative analysis.

On The 10th of May 1994 Nelson Mandela was inaugurated as the first democratically elected black president of South Africa. The occasion was regarded, both nationally and internationally, as a triumph for humanity and perfused with a widespread optimism for the future of South Africa. Mandela proclaimed in his inaugural speech that "Never, never and never again shall it be that this beautiful land will experience oppression of one by another.... The sun shall never set on so glorious an achievement." However, now, less than 10 years later the rapidly accelerating and devastating HIV/AIDS epidemic is again 'obscuring the sun'. Those people affected so negatively by the racial, economic and gender injustices of the apartheid past, seem again to be suffering a possible injustice, because of a health and welfare system that is struggling to meet the needs of the HIV affected population.

The purpose of this dissertation is to examine the concept of distributive justice in South Africa, within the context of this devastating epidemic. I begin by discussing the Bill of Rights in the South African Constitution. I argue that an acceptable framework for a theory of justice for health care in South Africa, must be worked out against the background of this egalitarian Bill of Rights. I then consider the extent of the HIV epidemic, the effect it is having on the people of South Africa and the consequent implications for health care needs.

It is within this context that I examine and compare three theories of distributive justice, namely utilitarianism, John Rawls' theory of "Justice as Fairness" and a libertarian concept of justice, as proposed by Robert Nozick. Utilitarianism is a consequentialist theory that focuses on producing the 'greatest happiness for the greatest number'. I argue that many health policy decisions in South Africa are in fact guided by this principle. However utilitarianism has both strengths and weaknesses which are critically examined. Within the framework of health care policy making, utilitarian justice dictates that rights are derivative and that the welfare of the majority usually takes precedence over the pressing needs of a minority. This issue in particular is discussed.

Rawls' theory of "Justice as fairness" is critically discussed next. This theory has been adapted to health care by Norman Daniels, who argues that the Rawlsian principle of "fair equality of opportunity" is a suitable founding principle for health care institutions. Apartheid entrenched a system of 'inequality of opportunity'. Consequently, a theory that focuses on equality of opportunity, has many advantages within the South African context. I examine this theory in detail and provide justification for my assertion that it could be usefully adapted to South African healthcare and the HIV/AIDS epidemic.

Finally, I discuss a Libertarian (Nozickian) theory of justice and examine both the strengths and weaknesses of this theory. I attempt to demonstrate why a libertarian system, with it vigorous commitment to moral and economic individualism and belief that one is only entitled to that share of healthcare that can be paid for, would be unjust, if rigorously applied within the post-apartheid South African context. I conclude my dissertation by re-iterating my assertion that "Justice as Fair Equality of Opportunity" could be used as a just foundation for a theory of justice for health care in current day, HIV/AIDS affected South Africa.

Teorieë van geregtigheid en 'n gesondheidsbeleid vir die VIGS epidemie in Suid Afrika : 'n vergelykende ontleding.

Op die 10de Mei 1994 is Nelson Mandela ingehuldig as die eerste demokraties verkose swart president van Suid- Afrika. Die geleentheid is in beide Suid-Afrika en in die buiteland beskou as 'n oorwinning vir humaniteit. Optimisme oor Suid-Afrika se toekoms was oral tasbaar. Mandela het in sy inhuldigingstoespraak verkondig dat dit nooit weer sal gebeur dat hierdie pragtige land sal ly onder die onderdrukking van een oor die ander nie. Hy het gesê dat die son nooit sal ondergaan op so 'n wonderlike prestasie nie. Nou, minder as tien jaar later, is die verwoestende VIGS epidemie besig om weer die 'son te laat ondergaan'. Dieselffde mense wat alreeds onder apartheid se rasisme en ekonomiese en geslagsongeregtighede gely het, blyk nou weer verontreg te word; hierde keer omdat die gesondheids- en welsynsisteem sukkel om in die behoeftes van die VIGS-geaffekteerde populasie te voorsien.

Die doel van hierdie verhandeling is om die konsep van distributiewe geregtigheid in die konteks van die dreigende VIGS epidemie te bespreek. Ek begin met 'n bespreking van die Verklaring van Regte soos vervat in die Suid-Afrikaanse Grondwet. Ek voer aan dat enige aanvaarbare teorie oor geregtigheid in die Suid-Afrikaanse gesondheidsisteem gegrond moet word op hierdie egalitêre Verklaring van Regte. Tweedens kyk ek na die omvang van die VIGS epidemie, die effek wat dit op die HIV-positiewe populasie en hulle familielede het, en die gevolglike implikasies vir gesondheidsbehoeftes.

Dit is binne hierdie konteks dat ek drie teorieë van distributiewe geregtigheid ondersoek en vergelyk; naamlik utilitarisme, John Rawls se teorie van "Justice as Fairness", en 'n libertynse konsep van geregtigheid soos voorgestel deur Robert Nozick. Utilitarisme is 'n konsekwensialistise teorie wat beteken dat die regte daad die een is wat in enige situasie die grootste geluk vir die meeste persone sal meebring. Ek voer aan dat baie van die beleidsrigtings wat 'n gesondheidsorg in Suid-Afrika gevolg is, deur hierdie teorie beïnvloed is. Utilitarisme het uiteraard sterk en swak punte en beide kante word krities ondersoek. In 'n gesondheidsorg konteks beteken utilitarisme dat regte altyd afgelei is en dat die welsyn van die meerderheid gewoonlik belangriker is as die van 'n minderheid, selfs wanneer die probleme van die minderheid ernstig en dringend is.

Rawls se teorie van geregtigheid word vervolgens krities bespreek. Hierdie teorie is deur Norman Daniels aangepas vir gesondheidsorg. Hy stel voor dat Rawls se beginsel van 'regverdige gelykheid van geleentheid' baie effektief aangepas kan word vir gesondheidsorginstellings. Apartheid het 'n sisteem van ongelyke geleentheids verskans; gevolglik hou 'n teorie wat gelykheid van geleentheid verseker baie voordele vir die Suid-Afrikanse situasie in. Ek bespreek hierdie teorie in detail en poog om my standpunt dat die teorie besonder geskik is vir Suid-Afrikaanse gesondheidsisteem – veral in die konteks van die VIGS epidemie – te regverdig.

Laastens bespreek ek die libertynse teorie van geregtigheid soos voorgestel deur Robert Nozick. Ek probeer aantoon waarom hierdie teorie, wat gebaseer is op morele en ekonomiese individualisme en gevolglik aanvoer dat mense geregtig is op gesondheidsorg alleenlik as hulle daarvoor kan betaal, onregverdig is in die Suid-Afrikaanse post-apartheid konteks. Ek sluit hierdie verhandeling af deur weer te argumenteerdat Rawls se teorie en die beginsel van 'geregtigheid as gelyke geleentheide' uiters geskik is as 'n grondslag vir gesondheidsorg in Suid-Afrika vandag.

To Dad

Engineer, turned 'Philosopher' of late
Thank you for your time and patience.

Table of Contents

Chapter 1. Pg. 1 – 5.
Introduction.

Chapter 2. Pg. 6 – 13.
The HIV/AIDS Epidemic in South Africa.

Chapter 3. Pg. 14 – 21.
Justice: Concept and Conceptions.

Chapter 4. Pg. 22 –30.
A Utilitarian Theory of Justice.

Chapter 5. Pg. 31 – 41.
Utilitarian Justice and the HIV/AIDS Epidemic in South Africa.

Chapter 6. Pg. 42 – 53.
An Egalitarian Theory of Justice:
John Rawls "Justice as Fairness"

Chapter 7. Pg. 54 – 63.
Rawls Theory of "Justice as Fairness" and the HIV/AIDS Epidemic in South Africa.

Chapter 8. Pg. 64 – 72.
A Libertarian Theory of Justice.

Chapter 9. Pg. 73 – 79.
Libertarian Justice and the HIV/AIDS epidemic in South Africa.

Chapter 10. Pg. 80 - 84
Conclusion

Bibliography. Pg. 85 – 91.

Chapter 1:

Introduction.

On the 10th May 1994 Nelson Mandela was inaugurated as the first democratically elected black president of South Africa. The occasion was perfused with pride, excitement and optimism for the future. In his inauguration speech Mandela proclaimed: -

> "To-day, all of us do, by our presence here confer glory and hope to newborn liberty. Out of the experience of an extraordinary human disaster that lasted too long, must be born a society of which all humanity will be proud. ..... We have at last achieved our political emancipation. We pledge ourselves to liberate all our people from the continuing bondage of poverty, deprivation, suffering, gender and other discriminations. Never, never and never again shall it be that this beautiful land will experience the oppression of one by another..... The sun shall never set on so glorious a human achievement."
>
> (Nelson Mandela. 10th May 1994)

Now, not ten years later, another dark cloud is obscuring the sun and threatening to decimate much of the 'human achievement' of the struggle to rectify the injustices committed by apartheid. This new 'human disaster' takes the form of the devastating and rapidly accelerating HIV/AIDS epidemic. Resources needed to restructure the economy, build houses and schools and create jobs seem set to be consumed by a humanitarian crisis of overwhelming proportions. An estimated 6 –10 million South Africans are expected to die of AIDS in the next 10 – 15 years. Some 40 – 50% of the current work force of South African companies is expected to die over the same time period. (Abt. Associates (LoveLife) 2000. Pgs 2-3) How will a nation still struggling to rectify the racial, economic and gender injustices of the past, cope with such devastation? Is it inevitable that those that suffered the injustices of apartheid will again suffer injustice; this time, because of a health and welfare system unable to cope with the needs of an often sick and dying, or orphaned and vulnerable people?

The purpose of this dissertation is to examine the concept of distributive justice, within the context of this devastating epidemic. In the introduction I shall briefly introduce the magnitude of the HIV/AIDS crisis, then discuss the Bill of Rights, which is incorporated into

the South African Constitution. This bill of Rights is 'the supreme law' of the land and therefore must form the background to a theory of distributive justice that could be used as a guideline to provide solutions to the HIV/AIDS epidemic and its consequences.

In Chapter 2, I shall discuss the HIV/AIDS epidemic in more detail and its implications for South African society and economy. I will also briefly sketch the natural history of the disease for the individual sufferer. This is necessary to determine the predicted health and welfare needs of those affected. Chapter 3 will introduce the concept of distributive justice and different conceptions of justice. I shall briefly outline utilitarian justice, Rawls' theory of "Justice as Fairness" and a libertarian theory of justice as articulated by Robert Nozick and explain and justify why I have chosen to explore these particular theories, within the context of the South African HIV epidemic. The remainder of the dissertation will include a detailed explication of each of these theories, their implications for health care policy in general and specifically within the context of the demands that the HIV/AIDS epidemic will place on society as a whole and on health and welfare structures in particular. I shall conclude the dissertation by attempting to show why I feel Rawls' theory of justice may provide some solutions to the problems we as a society will be forced to confront as a result of this devastating epidemic.

In 1995, the year following Mandela's inauguration it was estimated that about 1,2 million people in South Africa were 'HIV positive' and about (only) 20 000 people had AIDS (Evian, C. 1995 Pg 17) Doctors working in state hospitals and clinics were seeing patients with AIDS, with increasing frequency, but these patients were nevertheless a small percentage of the daily work-load. The problems of rebuilding South Africa and redressing the past apartheid injustices dominated the national psyche and media. The looming AIDS crisis remained in the background and those attempting to draw attention to it were often seen as prophets of doom, detracting attention from issues of understandable vital national importance, like the drafting of a new Constitution and Bill of Rights, and the Truth and Reconciliation Commission.

The South African Constitution which was signed into law on the 10th December 1996, after two years of intensive discussion and debate, states in the Introduction that it "represents the collective wisdom of the South African people". It is an egalitarian document, which incorporates an extensive Bill of Rights. As the "Supreme law of the Republic" it provides a background for any theory of distributive justice that could be

utilised to provide solutions to the management of the HIV epidemic. It is thus important to examine it, in particular its Bill of Rights, in some detail.

The preamble states that the Constitution is adopted as the supreme law of the republic so as to: -

> "Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights; lay the foundation for a democratic and open society in which government is based on the will of the people and every citizen is equally protected by law; improve the quality of life of all citizens and free the potential of each person."
>
> (Preamble to the Constitution of the Republic of South Africa)

The preamble thus commits the government to democracy and social justice. The concept of social justice is open to many interpretations and shall be the subject of this dissertation. What form of social justice will best improve the quality of life of all citizens and in particular those that are HIV positive and whose potential as persons without access or with limited access, to health care and social support, will never be freed?

The next section of the Constitution discusses the Bill of Rights and refers to this Bill of Rights as the cornerstone of democracy in South Africa and declares that "the State must respect, protect, promote and fulfil the rights in the Bill of Rights." The Bill comprises 13 pages and comprehensively discusses all aspects of civil society including freedom of speech, freedom of religion, freedom of assembly and demonstration etc. I shall discuss the sections of the Bill of Rights that are relevant to social justice and the HIV epidemic. Bracketed numbers refer to the numbered points in the Bill of Rights.

Rights to life, dignity and equality are stipulated as follows:-

- "Everyone has the right to life (11), inherent dignity and the right to have their dignity respected and protected." (10).

- "Everyone is equal before the law. ... Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons disadvantaged by unfair discrimination may be taken."(9)

This clause seems to imply that those previously disadvantaged should be compensated in some way so as to put them on an 'even footing' with those individuals not at a disadvantage. It appears to be influenced or to have its origin in Rawls' second principle of justice which incorporates the principle of fair opportunity and the difference principle. Rawls' principles of justice and their implications will be discussed in detail in Chapters 6 and 7.

Housing and healthcare, food, water and social security are discussed under points (26) and (27) of the Bill of Rights. The term "right of access" is used when addressing the issues of adequate housing and healthcare services, including reproductive healthcare; sufficient food and water and social security. (See point 27) The phrase "right of access" needs careful analysis and interpretation and may well mean different things to different people. To the libertarian 'right of access' to a healthcare service may simply mean a healthcare service, that must be paid for by the individual, but should be within a reasonable distance from the individual's home. To another, 'right of access' for an unemployed individual with no income or ability to pay, will by necessity mean a free service.

However section (27.2) states "The State must take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of each of these rights". Again the terms "reasonable measures" and "within its available resources" are open to vastly different interpretations. Available resources implies those resources specifically allocated to a particular social arena, e.g. housing or healthcare. The justification for a specific allocation, the perceived adequacy or otherwise of the allocation, should in a robust democracy be the subject of debate and dispute. Different theories of distributive justice would require significantly different resource allocations. For example a libertarian system of distributive justice would allocate minimal or no state resources to health care or welfare programmes.

The rights of children are discussed under point (28) in the Constitution in considerable detail and are especially relevant within the context of the HIV epidemic. The UNAIDS 2002 Epidemiological Fact Sheet for South Africa states that at the end of 2001, 250 000 children were living with HIV/AIDS and that there were 660 000 living orphans, under the age of 15.

According to the South African Constitution every child (defined in the constitution as a person under the age of 18) has the right to

- "family care or parental care, or appropriate alternative care, when removed from the family environment,
- basic nutrition, shelter, basic health care services;
- be protected from maltreatment, neglect, abuse or degradation; ..." and
- "A child's best interests are of paramount importance in every matter concerning the child."

It is very important to note that here the phrase "right to access" when referring to shelter, nutrition, healthcare and social services which was used in point (27) when referring to adults, has been replaced by " right to". The word "access" has been left out.

I think few would dispute the fact that for many children living in rural areas and particularly for those affected directly (i.e. infected) or indirectly (i.e. orphaned, or as children of parents sick or dying as a result of the HIV/AIDS epidemic), these rights have not been fulfilled. As the epidemic progresses the number of children adversely affected will increase. Projections estimate that by the year 2010, 22% of children under 15 will be maternal orphans. (Whiteside, A.1998. Pg 49) The South African Constitution stipulates that a minimal conception of justice requires the acknowledgement and fulfilment of the rights as laid down in the Constitution. Rights appear to have a narrower scope than justice (Campbell, T. 1988. Pg 37) but authors like Ronald Dworkin believe that rights should form the foundation of justice and the judicial system and ensuring that justice is done, is a matter of determining what rights persons have and treating them according to those rights. (Dworkin, R. 1978.Pg 130) I shall discuss the relationship between rights and justice in more detail in Chapter 3.

I have briefly introduced the depth and severity of the HIV/AIDS crisis in South Africa and have framed the problem with the egalitarian South African Constitution and set it on the background of apartheid injustices and post apartheid challenges. I shall now examine the HIV/AIDS epidemic in more detail.

Chapter 2

The HIV/AIDS Epidemic in South Africa

I shall now discuss the current status of the HIV epidemic in South Africa and its predicted effect on the people of South Africa. In particular I shall attempt to determine the healthcare needs of those affected and the implication these needs will have on prevailing healthcare systems and structures. A thorough understanding of the scope and magnitude of the HIV/AIDS epidemic is needed if a theory of justice is to be promulgated that will provide some guidance to the just management of this crisis.

The progression of the HIV epidemic in South Africa, has been monitored almost exclusively by the annual ante-natal anonymous HIV and syphilis sero-prevalence study. HIV infection levels in the general S.A. population are probably lower than reflected by these figures because children and the elderly are not included. However fertility rates among HIV positive women are thought to be significantly lower than in HIV negative women, probably resulting in under reporting. Various computer models are then used to extrapolate these figures to the broader population. This survey is also used to provide future estimates of the course of the epidemic and its effect on the population and the South African economy. Obviously mathematical and computer modelling have their limitations and drawbacks, but are currently the only available methods of evaluating the current epidemic and predicting the future. They are generally accepted as being reasonably accurate. (Whiteside, A. 1998 Pgs 61-74)[1]

The most recent Ante-Natal Sero-prevalence Survey available is for the year 2001. This is the twelfth annual report of the status of HIV prevalence in South Africa; the first being in 1990. The epidemic followed an exponential rise between 1990 and 1998 and now appears to have reached a plateau. 24,8% of women tested nationally in 2001 at public health facilities were HIV positive, compared to 24 % in 2000 and 22.8% in 1998. However, in 1990 when the survey was initiated, less than 1% of women were positive. Nationally there are significant differences in prevalence with 33.5 %(36,2% in 2000) of women in Kwa-Zulu Natal testing positive, compared to 8.6 %(8,7% in 2000) in the Western Cape. Women in their twenties consistently show the highest prevalence rates for HIV infection. In the year 2001 (2000 figures in brackets) 28,4% (29,1%) women in the 20-24 year age group tested positive and of those in the 25 –29 year age group

31.4%(30,6%) tested positive. Positivity rates in women in the under 20 age group are now showing a downward trend and were 15,1% in 2001.

As discussed earlier, in general no direct statistics are available for prevalence rates in other sections of the population, but these results are extrapolated, by the Department of Health, to estimate infection rates in the general population which are as follows:-

- Women aged 15-49 2.65 (2.5) million
- Men aged 15-49 2.09 (2.2) million
- Babies 83 581 (106 109)
- Children aged 1-15 250 000

However studies conducted in defined local populations appear to validate these extrapolations. E.g. study done among tertiary education students at the University of Durban Westville in Kwa- Zulu Natal showed that 26% of women and 12% of men aged 20 – 24 and 36% of women and 23 % of men aged 25 –29 were currently infected. (Abt Associates. 2000. Pg 7)

A total of 4.7 million South Africans are now estimated to have been infected with the HI virus by the end of 2000, i.e. approximately 1 in 9 South Africans. Of these 4.7 million HIV infected South Africans, the majority are currently still well; many asymptomatic. The devastating implications of this prevalence figure in terms of mortality, and more explicitly, in terms of decimation of family life and economic structure, has yet to be felt.

In September 2001 the Medical Research Council of South Africa (MRC) released a report entitled "*The Impact of HIV/AIDS on Adult Mortality* in South Africa." (Dorrington, R. et al 2001) This report was based on a combination of demographic data, mortality statistics and a mathematical model called ASSA 600 developed by the Actuarial Society of South Africa. The opening line of the executive summary states "South Africa is experiencing an HIV/AIDS epidemic of shattering dimensions." Routine mortality statistics show that a definite shift in the age pattern of mortality from natural causes, has occurred over the last ten years, from old to young, most notably in women. The mortality rate for women in the 25-29 year age group in the year 2000 was 3.5 times that experienced in 1985 (Ibid. Pg 5). This shift is attributable to death from AIDS.

Currently, as stated earlier, it is estimated that 4.2 million South Africans are living with HIV. This is more than any other single country in the world. (Ibid Pg10) The MRC report

predicts that between 2000 and 2010, 4-7 million South Africans will die of AIDS. In the year 2000, 40% of the adult deaths in the 15 to 49 age group were estimated to have been AIDS related, as opposed to 26 % in 1998, or 9 % in 1995.(Ibid Pg 30) Overall 17% of all deaths recorded in 2000 were HIV related. AIDS has now become the single biggest cause of death in South Africa. Over the last decade the population of South Africa grew by 37%. During the same period the death rate grew by 73 % (Ibid Pg 18). The epidemic will have an early impact on the Infant Mortality Rate causing this to rise instead of continuing to decline. The mortality of 'under 5-year olds' is expected to double. The current levels of premature adult mortality will rise dramatically. The chances of a 15-year old dying before the age of 60 will more than double, with an estimated 800 out of every 1000 people dying before the age of 60 by the year 2010. (Ibid Pg 21) Justice Edwin Cameron said in his opening address to the AIDS 2000 Conference in Durban, "The statistics are so horrifying that the imagination shrinks from the thought that these figures represent real people and real suffering" (Adler, G. 2002 Pg 140)

These estimates work on the assumptions used by the ASSA 600 model, that Mother to Child (MTC) transmission rates are 25 % with a further 10 % of babies becoming infected post-nataly. HIV positive infants are expected to die at a rate of 30 % per annum and the median survival rate, from infection with HIV, to death is 10 years.

Current estimates suggest that about 500 000 people in South Africa are AIDS sick. While in itself a large figure, this represents a relatively small percentage (3%) of the total population. Most South Africans have yet to feel the devastating effects of this epidemic and as a result have yet to make the behavioural and lifestyle changes needed to cope with the consequences of AIDS when they as individuals, become directly or indirectly affected. If 24 % of the adult population is currently HIV positive then in the next 5-10 years one in two families can expect to lose either the mother or father; some families may lose both parents. This scenario is devastating. If added to the economic and social inequalities and injustices left in the wake of apartheid South Africa, the crisis is even more profound. Population censuses to date indicate that less than 60 % of South Africans live in formal housing; the remainder living in shacks or traditional dwellings. Some 17 % of households still obtain water directly from dams, rivers or boreholes. Fewer than 30 % have telephones and almost 50% have no sanitation (i.e. flush or chemical toilets). Unemployment is high, with 34 % of the adult population unemployed and 26 % of those employed earning less than R500 per month. (Abt Associates (LoveLife) 2000 Pg 9)[2] Thus

at least one third of South African households are living in conditions of extreme poverty where day to day living is a continual struggle. How will these households cope when the breadwinner or mother is sick or dying or has died? Who will bury the dead, let alone counsel the grieving, clothe and educate the children left behind, treat the sick and nurse the dying?

Apartheid affected black South African women profoundly. Families were torn apart by the migrant labour system. They were severely affected by a government that curtailed all basic rights and liberties including freedom of movement and the ability to seek employment, or gain access to even the minimal health services, housing or education. For women confined to homelands, with no land rights or income and absent partners, life was simply a daily struggle for food and basic survival. Traditional culture often further entrenched the subordinate, powerless role of women. The HIV epidemic again threatens to erode what small gains women have made in terms of human rights and economic upliftment. This epidemic in Africa, has demonstrated with out a doubt, that AIDS flourishes in societies where women are vulnerable (Van Niekerk, A A 2002. Pg 154) Biological factors result in women being more easily infected than men. Their subordinate role within traditional households means they are often unable to negotiate adequate protection in the terms of condom use. Poverty and poor education may mean that they are unaware of the risks they are facing. Economic deprivation means that women are often coerced into exchanging sex for money. The recent *LoveLife Youth Survey* [3] revealed that 16 % of girls questioned, indicated that they had exchanged sex for money or other commodities. Domestic violence appears to be pervasive in South African society, with at least 10 % of women being the victims of some form of domestic violence. Increasingly, men, aware of the threat of AIDS, are seeking out young women (girls) for sex. 9.5 % of pregnant girls under the age of 15 tested positive for HIV in 1997. (UNAIDS Fact Sheet 2000. Pg 2) The power discrepancy in such relationships means that condom use is unlikely.

Women fear the stigmatisation that a positive HIV status brings and thus are often reluctant to seek counselling or testing, or to reveal their positive status (once this has been determined) for fear of abandonment. A study reported by UNAIDS found the frequency of reporting of needle-stick injuries, by nurses in primary healthcare clinics to be very low. The underlying reason was found to be the fact that the current public health policy requires anyone reporting a needle-stick injury to undergo an HIV test. The fear of

having a positive result was such, that most nurses chose rather not to disclose the incidents, then risk discovering that they were in fact HIV positive. (UNAIDS 1998 AIDS Fact Sheet Pg 6)

Apart from domestic violence, rape, is a common occurrence in South Africa. Statistics released by the South African Police Service, report 54 000 cases of rape in South Africa in 1998.This means that South Africa has the highest reported rape incidence per capita in the world (115.6 per 100 000 population in 1980. If only 1 in 20 rapes are reported then an excess of I million rapes occurred in 1998 at a rate of 2976 rapes per day or more than 2 a minute. It is widely accepted that rape and sexual assault are significantly underreported .and that the real figure may be up to 20 times higher than the reported figure.(Statistics supplied by Rape Crisis SA) Traumatic sex significantly increases the chance of contracting HIV infection. The recent South African Youth Survey by LoveLife found 39 % of sexually experienced girls reported that they had been forced to have sex when they did not want to, 33 % of the girls reported that they are sometimes afraid to say no and alarmingly, 35 % of sexually experienced boys indicated that they would not accept no for an answer.

Once infected with HIV, a woman has an approximately 25 % chance of passing this infection on to her unborn child. If she breast feeds the baby (which she often must do because she cannot afford formula milk) she has an added 10 to 15 % chance of infecting the baby. If she chooses not to breast feed she is often stigmatised by the community. If her baby does get infected she must care for a child that will suffer from many unpleasant infections, like diarrhoea and pneumonia and will probably die before his second birthday. If her child is not infected then she has to bear the burden of knowledge that she will die probably before the child's 5th birthday and someone else will have to care for her baby

It is the women in South African society who must care for the sick and the dying, often when they are already sick themselves. Those who are dying may well have been the breadwinners in the past. Thus the future that appears to await women in South Africa is bleak at the best and more often than not, quite devastating. Nelson Mandela's pledge to "liberate all our people from the continuing bondage of poverty, deprivation, suffering, gender discrimination", seems doomed to fail unless the problems discussed here are somehow addressed in a practical, compassionate, non-discriminatory and coherent manner.

In order to paint a fully comprehensive picture of the HIV crisis facing South Africa and to attempt to propose some solutions in terms of a just distribution of resources, it is important to focus briefly on the individual infected with HIV and to understand the natural history of the illness. This understanding is needed to predict the care and resources this individual will need during the course of his or her illness.

HIV produces a relentless, progressive and ultimately fatal immunodeficiency syndrome in the vast majority of infected, untreated patients. (Venter, F. 2002 Pg 12) Most patients experience a flu-like illness that usually lasts less than two weeks at the time of seroconversion, usually one to two months after infection. This illness is mild and is often dismissed by the patient or doctor as nothing more than 'flu'. Patients will test HIV positive within 21 days of this illness. Viral levels in the blood are very high during seroconversion but fall to a stable level once the host's immune response to the infection is established. The CD4 count, a measure of cellular immunity, starts to drop at a steady rate of about 40-80 cells per micro litre per year from a normal level above 600. Some patients will experience a more rapid decline than others, resulting in patients being labelled as 'fast', 'slow' or non-progresses. The falling CD4 count reflects a steady loss or damage to the immune system.

The average time from infection to full-blown AIDS is about 10 years, but is determined by a complex interaction between the patient (host), the virus and the environment. A "train on a track heading for a broken bridge" model has been used very effectively to illustrate this interaction. The train represents the HIV infected patient, the track is the CD4 count and the speed of the train is the viral load. A patient with a high CD4 count, i.e. lots of track, may have a high viral load (train travelling fast) and thus reach the bridge (immune decompensation or AIDS) fairly quickly. Alternatively a patient with a low viral load (train travelling slowly), will take longer to reach the bridge, especially if his CD4 count is still high (lots of track). Anti-retroviral treatment decreases the viral load (slows down the train) and increases the CD4 count (extends the track). An effective care system would enable viral load and CD4 count monitoring, in order to predict when the 'train will hit the bridge". Adequate nutrition and prophylactic treatment will also slow down the train and lengthen the track.

Once the train hits the broken bridge the patient will get an increasing number of severe opportunistic infections which will require ongoing care and treatment, and often hospitalisation. Without this care, death will follow rapidly. (Venter, F. 2002. Pgs 13-14) Once the CD4 count has reached 350 cells/micro litre (normal level above 600), previously asymptomatic patients will start getting ill; e.g. weight loss, oral thrush, skin rashes, diarrhoea, and recurrent respiratory tract infections. With a CD4 count of 200, patients will have AIDS and present with severe opportunistic infections such as cryptococcal meningitis and extra-pulmonary tuberculosis. International guidelines recommend preferably starting anti-retroviral medication at a CD4 count of 350 and definitely starting it at 200. Anti-retroviral drugs markedly reduce viral loads, often to barely detectable levels, thereby allowing the immune system to recover, increasing the quality of life of the patient and decreasing HIV related morbidity and mortality. (Andrews, S. July 2002. Pg 18) Mortality rates among patients in the United States with AIDS, but who are being treated with Anti retroviral agents, demonstrate a dramatic reduction since 1994 when ART was first introduced.(Pallella, F et al 1998 Pg 853) However currently Anti-Retroviral Treatment is only available to those South Africans who are able to pay for it. The vast majority of HIV infected South Africans will not receive what is regarded in the Western world as the standard care for HIV infections, because this treatment is expensive and largely unaffordable. Once the CD4 count has reached 200 all HIV positive patients should be offered chemoprophylaxis against various opportunistic infections. The cost of this medication which must now be taken for life is inexpensive but presupposes that the patients CD4 count has been regularly monitored, at least 6 monthly. The CD4 count investigation is very costly (approximately R230.00 per test) and must be done by skilled personal in a sophisticated laboratory.

Eventually, usually about 10 years after infection, most HIV infected individuals will develop what is commonly described as 'full-blown AIDS' and become increasingly debilitated with one opportunistic infection after another. They will become bedridden and terminally ill and need ongoing care and assistance with most aspects of daily living. This stage may last from a few months, to a year or two, before death intervenes. Obviously, access to Anti-Retroviral medication has a significant effect on the course of events at this stage of illness. Many HIV positive persons, who contracted the disease in the mid 1980's are still leading active lives today because they have had access to Anti-Retroviral Treatment (ART). The director of the SA AIDS foundation comments in a report on the Barcelona AIDS Conference that "Triple drug therapies have been proven to be most

effective in managing HIV as a chronic illness. The sense of panic and fear that dominated First World AIDS communities has dissipated and attention is now focused outwards to countries that are still experiencing devastating epidemics." (Adler, G. 2002. Pg 14)

The purpose of this dissertation is to address the question of distributive justice in terms of finding solutions to the economic and physical burden placed on our society and the individual, by this epidemic, However, the emotional pain, stigma, trauma and grief must remain largely un-addressed here, but should never be forgotten and in many ways is as profound and devastating a problem, as the more tangible economic one. The questions that need to be asked and answered are :

- How should the burdens of this epidemic be distributed?
- How much of this burden should the individual HIV positive person carry and how much should be the State's responsibility?
- What of society in general and particularly those as yet unaffected? What role do they have to play?

I hope that an examination of the concept of 'justice' and an analysis of the different conceptions of justice within the context of HIV/AIDS and South Africa, may be helpful in providing some insights to this perplexing, challenging and devastating problem.

Notes

1. According to Whiteside, a model is a "concept or hypothesis that tries to explain the real world. It provides a theoretical framework, that allows the design of various tools to provide answers to question about this "model world". The tool being a mathematical formula or computer program, is often referred to as "the model". This is somewhat inaccurate since the term "model" refers to the hypothesis, i.e., the basic theoretical assumptions, or at least it includes them." A wide range of different approaches have been used to project future HIV prevalence rates. The two most widely used models in South Africa are the Doyle Model which was first published in 1990 and the ASSA model (Actuarial Society of South Africa) These models are both regularly updated and have, over time, proved to be fairly accurate with predictions matching reported statistics. The Doyle, or Metropolitan Life Model, in particular has been used extensively. The ASSA model however, is used in the MRC Mortality report.
2. and 3 "LoveLife is the largest and most comprehensive effort ever launched in South Africa to positively influence adolescent sexual behaviour, to reduce the risks of HIV infection, teenage pregnancy and sexually transmitted diseases It aims to reduce HIV infection among 15 to 20 year olds by 50 % in the next 5 years" LoveLife is sponsored by the American Henry J Kaiser Family philanthropic Foundation.(Quoted from the preface to *The Impending catastrophe: a resource book on the emerging HIV/AIDS epidemic in South Africa*. (See Bibliography)) This NGO has commissioned several research projects and produced various reports on the subject of HIV/AIDS in South Africa e.g. The Love Life Youth Survey which examined sexual knowledge and practices in adolescents, from all cultures and

backgrounds in South Africa . They have also published various educational booklets aimed particularly, but not exclusively at teenagers.

Chapter 3

Justice:- Concepts and Conceptions.

"Justice is much more valuable than gold", declared Socrates in Part One of Plato's Republic. Socrates then proceeds to demonstrate in his arguments and rhetoric with various opponents, just how difficult a concept justice is to actually define. *The Oxford Companion to Philosophy* describes justice as "identical with the ethics of who should receive benefits and burdens, good or bad things of many sorts,...". (Honderich, T. 1995. Pg 433) Aristotle's principle of formal justice, "to treat equals equally and unequals unequally" is a minimal requirement of all common theories of justice. Who counts as equal or unequal must be determined and justified. (Beauchamp, T. Childress, J. 1994. Pg 329) Aristotle himself favoured a meritorious conception of justice.

Discussions around justice involve firstly an analysis of the *concept* 'justice'. What does the concept mean? What constitutes the boundaries of justice? Are there different types of justice? Secondly, an analysis of justice looks at differing *conceptions* of justice and attempts to define justice in concrete terms and by so doing, according to Campbell "enters into the disputed area of contentious political debate". (Campbell, T. 1988. Pg 4) Thus if the concept of justice means to treat equals or unequals equally, then differing conceptions of justice will attempt to justify a set of principles which defines who counts as equals, or unequals respectively. Alternatively, if we use what Miller describes as the most useful general definition of justice, ("because it brings out its distributive character most plainly") that is to give each man his due, then different conceptions of justice will argue differently as to what counts as 'due'. (Miller, D. 1976. Pg 210)

The concept of justice is commonly used in at least three different contexts, although all contexts are in a sense 'distributive'. Distributive justice, which is the subject of this dissertation, involves the distribution of social benefits and burdens. Criminal justice, or retributive justice refers to the just infliction of punishment through criminal law, and rectificational justice, or corrective justice concerns the ethical "appropriateness of compensating with some good because of a loss and or appropriating a good because of an unfair gain" and includes issues such as breach of contract. (Honderich, T. 1995. Pg 433; Beauchamp, T. Childress, J. 1994 Pg 327)

After defining the *concept* of justice, it is necessary to consider differing *conceptions* of justice. These conceptions may be expressed as one or more material principles of justice, or may be presented as a more general theory of justice. Principles of justice may be easy to apply and readily accepted in one set of circumstances, but regarded as contentious in another situation. For example, few would dispute distributing places at a university according to merit or desert, but distributing welfare on some system of merit would be disputed by many and regarded as an injustice, rather than an example of justice. Other principles of justice pose similar problems and often seem to raise questions rather than provide answers. Examples of conflicting principles of justice are,:-

- to each according to need, or
- to each according to contribution, or
- to each according to an equal share, or
- to each according to his rights, or
- to each according to his ability to pay, or
- to each according to his ability and talents.

(Beauchamp, T. Childress, J. 1994. Pg 330)

Obvious questions that arise from these principles are, for instance:- What counts as need? To what rights am I entitled and why? Should distributions be made according to talent or ability, especially if the ability is due to natural good fortune? Is an equal share just, if one party's needs are much greater than another's? Such questions seem interminable and the answers never without controversy. Material principles of justice, thus often provide very little help in illuminating the vexing problem of how society's benefits and burdens should be distributed. It is for this reason that philosophers have attempted to articulate broader theories of justice, that can be applied to society as a whole, rather than individual material principles that may only be applicable to one particular field and are liable to come into conflict with other principles.

The 18th Century Scottish philosopher David Hume's analysis of the *concept* of justice is that justice is a convention or method of maintaining social order, by settling disputes between individuals making conflicting claims on limited resources. Justice in Hume's view is thus mainly concerned with a system of property, or the distribution of benefits and burdens and especially the distribution of scarce resources. Injustice occurs in situations where an individual or group wrongly receives greater or less than others similarly situated. (Campbell, T. 1988. Pg 12) Justice concerns the distribution of 'goods', either

tangible, (e.g. property) or intangible, (e.g. 'position' or punishment). Hume's particular *conception* of justice however, is that of the rule utilitarian.(See Chap 4)

Rawls also distinguishes between the concept of justice and conceptions of justice. He acknowledges that there are many things labelled as just or unjust, (e.g., laws, institutions, social systems and actions or decisions), but confines his discussion to social justice, or the way society's benefits and burdens are distributed. He says " The concept of justice I take to be defined then by the role of its principles in assigning rights and duties and in defining the appropriate division of social advantages. A conception of justice is an interpretation of this role" (Rawls, J. 1999. Pg 9)

For the purpose of this dissertation, I will follow Rawls' interpretation of the *concep*t of justice as meaning social justice, or more precisely social distributive justice. That is, what principle or principles should determine the distribution of society's benefits and burdens? This question has particular bearing in the society that is South Africa at the beginning of the 21st Century, currently in the grip of a devastating natural epidemic that has profound social and economic implications.

I have now established the limits to the *concept* of justice that I shall use for this discussion and will briefly introduce the three different *conceptions* of justice that I intend to discuss. I will justify my decision to illuminate these specific conceptions. I shall also briefly discuss the connection between justice and rights, which is particularly relevant within the context of justice and health care and in the light of the fairly extensive Bill of Rights tabled in the South African Constitution and discussed in Chapter 1.

Conceptions of justice have been a matter of in-depth philosophical debate and enquiry for several centuries. This debate has intensified and proliferated in the 20th Century, especially after the publication of John Rawls' landmark 'A Theory of Justice' in 1971. As mentioned, I shall discuss three theories, or conceptions of justice in this dissertation because I believe they are particularly relevant to South African society today. However, there are of course other theories of justice, which are also relevant and will be briefly introduced. It is beyond the scope of this dissertation to include all theories of justice or political systems that determine the distribution of societal goods.

A utilitarian theory of justice was promulgated by David Hume, the 18th Century Scottish philosopher and documented in "*Enquiries Concerning Human Understanding and Concerning the Principles of Morals".* (1751) However the main proponent of utilitarian justice is John Stuart Mill and his theory is documented in Chapter 5 "On the Connection between Justice and Utility" of *Utilitarianism*. The essence of a utilitarian theory or conception of justice is based on only one principle. The just action is one that maximises utility or will produce "maximum happiness (utility) and the least amount of unhappiness, (disutility). This is a teleological theory, which focuses on outcomes or consequences. A just act produces the best overall outcome when everything and everyone involved is taken into consideration. Utilitarianism is a seductive theory, especially when taken at face value, as it often is, according to Barrow.

> "Utilitarianism is probably the most widely subscribed to and practically significant ethical theory in the Western world. That is not to say that most people would claim to be utilitarians. In all likelihood very few would. But many people who do not see themselves as utilitarians effectively behave as if they were. Many arguments public and private, unconsciously take utilitarianism for granted, and many of our social, legal and institutional arrangements presuppose utilitarianism."
>
> (Barrow, R. 1982. Pg 12)

Much public policy and particularly health policy, is justified on utilitarian grounds. It is thus an important theory to consider carefully. However it does have major limitations and significant implications, especially regarding individual rights and interests. These will all be explicated in detail later.

The second theory or conception of justice I shall consider, is the egalitarian theory proposed by John Rawls in his 1971 book *"A Theory of Justice*", which he refers to as "justice as fairness". Its publishers, Oxford University Press, have described this work as "perhaps the most important work of moral and political philosophy of the 20th Century" and it has been the subject of countless critiques and commentaries. Rawls' theory is in direct conflict with utilitarian justice and is built around the concept of separateness of persons or each individual "being the separate centre of moral values". (Ryan, A. 1993. Pg 13) It is a contract based egalitarian theory, consisting of two essential principles. The first requires the equal distribution of fundamental rights and liberties, and the second

requires that (a) "social and economic inequalities are to be arranged so that they are both reasonably expected to be to everyone's advantage and (b) attached to positions and offices open to all." (Rawls, J. 1971.(revised edition 1999) Pg 53) Rawls' theory attempts to ameliorate those disadvantaged by life's "biological or social lottery". It is thus of particular relevance to South Africa and deserves careful consideration when discussing an appropriate theory of justice within this context. Also the South African Constitution is an egalitarian bill of rights that appears to have been influenced by Rawls' conception of "justice as fairness" .

Finally a libertarian theory of justice will be considered, because this conception of justice is prevalent in the Western world and forms the basis of a free market economy. The central idea of libertarian justice is that the rights of personal liberty and property must be protected by the State. Individuals are free to improve their lot in life by personal initiative. (Beauchamp, T. Childress, J. 1994. Pg 336) Any State intervention in the free market or individual wealth and property, for redistribution purposes, e.g. taxes, is unjust. Robert Nozick, one of the main proponents of libertarian justice believes the term distributive justice is a misnomer, because it implies a central agent who has the authority to distribute or re-distribute goods and there is according to him, no such thing. His entitlement theory discusses the subject of "justice in holdings" whereby "holdings" implies property. He proposes three principles of justice that govern the acquisition and transfer of holdings. A just society according to Nozick, is one that upholds these three principles.

As the South African economy is a free market economy and the access to certain forms of health care e.g. Anti-Retroviral treatment, is currently determined to a large extent by the ability to pay for it, the libertarian theory of justice is particularly relevant to us and shall be examined in detail, as the third theory of justice.

As mentioned, although the above theories represent the three most prominent theories in current philosophical-political debate, they are not the only conceptions of justice. Communitarians dispute the relevance of a theory of justice based on a single principle, or one or two principles focused on individual rights and contracts. Communitarians such as Alisdair McIntyre and Michael Walzer, propose a pluralistic theory of justice that is derived from a particular community's conception of the good. Communitarians emphasise the balance or interplay between the community's responsibility to the individual and the individual's responsibility to the community. Conceptions of justice are not external to a

society but are "Standards developed internally as a political community evolves." (Beauchamp, T. Childress, J. 1994. Pg 339) Communitarian conceptions of justice undoubtedly have a part to play as a positive counterbalance for excessively individualistic conceptions of justice, but the exact implications of these theories are often not clearly defined. Attempting to work out a communitarian theory of justice in multicultural, interwoven, pluralistic society like South Africa might prove difficult to achieve and has thus not been attempted here.

Marxist and socialist theories, although considered to be political ideologies could also be discussed in a dissertation on distributive justice. However Marxism and more radical versions of socialism in particular, are not prominent current political ideologies in the Western world or South Africa, having fallen out of favour in the last two decades and are unlikely to greatly influence distributive justice within the context of the present-day HIV/AIDS crisis. Consequently and partly due to time and space constraints, they have not been included in this dissertation.

It is now necessary to briefly discuss the relationship between justice and rights. Justice is closely related to a respect for rights and often a typical example of an injustice is an infringement of rights. This accepted connection between justice and rights was historically not always present. Greek political theory and Roman law produced detailed accounts of justice that did not include our present day conception of individual rights. Property and authority were defined by law, not by an idea of individual rights (Ryan, A. 1993. Pg 2) Philosophers from Hume onwards have discussed justice and rights or entitlements together. "The idea that individuals have rights captures also the belief that the possession of rights enhances the dignity of the rights holder and so exemplifies the idea of 'respect for persons', which is often said to be at the core of what it is to treat people justly." (Campbell, T. 1988. Pg 37) Writers like Ronald Dworkin regard rights as 'trumps' and frame justice entirely in terms of determining what rights people have and ensuring that they are treated according to their rights (Ibid Pg 45) One problem with 'justice as rights' is that a great deal of emphasis is placed on individual liberty and property which can be seen as counter-intuitive to an egalitarian society concerned with the welfare of all, that many see as the overall aim of justice.

> "It may be that many rights give individuals unreasonable powers of veto over important social objectives whose justification is their contribution to

> justice. With its emphasis on individual choice and the liberty of the individual, the theory of justice as rights often turns out to be an ideologically partisan theory in which liberty is favoured disproportionately over equality."
>
> (Campbell, T. 1988. Pg 38)

Libertarian writers like Robert Nozick believe we are born with, or acquire 'entitlements' and justice ensures that these entitlements are not unfairly taken away from us. Rawls on the contrary, believes justice is the 'first virtue of social institutions' and rights are those dictated by principles of justice. This view point is echoed by Norman Daniels, who says, while discussing rights and health care that "a pragmatic appeal to rights does not carry us past our disagreements and uncertainties about the scope and limits of such rights claims. We are justified in claiming a right (to healthcare) only if it can be harvested from an acceptable, general theory of distributive justice..." (Daniels, N. 1985. Pg 5) Hence the concepts of rights and justice are tightly interwoven and difficult to separate. The South African Constitution's detailed Bill of Rights must at least be compatible with a plausible theory of justice for health care in South Africa.

Finally, I will briefly comment on the relationship between justice and health policy. Decisions at an institutional level (hospital, local government, or state) determine what kinds of healthcare services are available, to whom and on what basis; who will provide the services and who will fund them. These decisions effect the "level and distribution of the risk of our getting sick," the chance of our getting adequately treated and recovering and the degree of support available, if we remain ill. These decisions fundamentally affect the "level and distribution of our well-being", and thus involve issues of social or distributive justice. (Daniels, N. 1985. Pg 3) Principles of justice, or a broader theory of justice, are needed to provide a framework for determining how basic institutions like health institutions should be structured. They should also serve as a "public and final basis" for resolving disputes and assisting "planners and legislators to make specific policy decisions."(Ibid Pg 4) The remainder of my dissertation will be taken up with this task i.e., of attempting to determine which, if any, theory of justice can adequately address issues of distributive justice raised by the health care crisis caused by the legacy of apartheid and the HIV/AIDS epidemic in South Africa.

Chapter 4

A Utilitarian Theory of Justice.

Jeremy Bentham (1780-1832) and John Stuart Mill (1806-1873) are generally regarded as the fathers of utilitarianism, a moral theory that is based on one principle only - the principle of utility. However, philosophers like David Hume, writing in 1751, a century earlier, also give a utilitarian account of justice. In this chapter I shall first briefly discuss utilitarianism in general and then proceed with a more detailed explication of the utilitarian theory of justice, focusing on Mill's account of this theory. I will them discuss some criticisms of utilitarianism and also look at its strengths. In the subsequent chapter I shall specifically discuss the application of utilitarian justice to health care and the HIV/AIDS epidemic.

The principle of utility dictates that the morally right act is the one that maximizes value over disvalue. (Beauchamp, T. Childress, J 1994. Pg 4). What makes an action right, are its consequences.

> "The creed which accepts as the foundation of morals, Utility, or The Greatest Happiness Principle, holds that actions are right in proportion, as they tend to produce happiness, wrong as they tend to produce the reverse of happiness. By happiness, is intended pleasure and the absence of pain, by unhappiness pain and the privation of pleasure. "
>
> (Mill, J.S. 1871. Pg 91)

Bentham and Mill were hedonistic utilitarians because to them utility was conceived of, in terms of maximum pleasure and minimum pain. They did recognize that "some kinds of pleasure are more valuable then others"(Ibid Pg 11) and believed quality and quantity should both be taken into account. Mill also believed that pleasures involving the use of the intellect ranked above the more basic pleasures e.g. food and sex. He acknowledges that those capable of higher pleasures "occasionally, under the influence of temptation postpone them to the lower. But this is quite compatible with a full appreciation of the intrinsic superiority of the higher " (Ibid Pg 97)

Modern utilitarians regard other values, such as friendship, knowledge, health, beauty and personal autonomy, as intrinsically good for their own sake, not merely as means to

pleasure. (Beauchamp, T. Childress, J. 1994. Pg 48). Preference utilitarians believe what people prefer should be taken into consideration when attempting to calculate the balance of maximum good. (Pence, G. 2000. Pg 18)

Another important component of utilitarianism is impartiality, or as Jeremy Bentham supposedly stated " Everybody to count for one, nobody for more then one" (Hare, R. M. 1998. Pg 82) When the balance of value and disvalue is being calculated all parties affected, must be considered from a disinterested impartial point of view.

Two main versions of utilitarianism exist, namely act utilitarianism and rule utilitarianism. Act utilitarians view each moral dilemma or act individually and seek the answer to the question, what good or bad outcomes will occur if Act X, or alternatively Act Y is carried out? Act utilitarianism however, seems to suggest that in certain circumstances, actions considered by common morality as abhorrent, are permissible and even obligatory. An example often used is that of killing a vagrant in order to use his organs to save the lives of three or four very productive or important individuals. (Hare, R. M. 1998. Pg 84; Upton 1993. Pg 194). Rule utilitarians counter this allegation, by adopting rules that, when followed, ultimately result in the maximization of utility e.g., killing of innocents is wrong or truth telling in medicine is always obligatory. Worthington Hooker, a well recognized physician and rule utilitarian in the 1900's proclaimed:

> "The good, which may be done by deception in a few cases, is nothing compared with the evil which it does in many.... And when we add to this the evil which would result from a general adoption of a system of deception, the importance of a strict adherence to the truth in our intercourse with the sick....becomes incalculably great."
>
> (As quoted in Beauchamp, T. Childress, J. 1994. Pg 51)

Act utilitarians regard rule utilitarians as often not utilitarians at all, because by sticking to rules, utility is, in particular circumstances, not in fact maximised. Rule utilitarians, on the contrary, see observance of rules or principles, as often the only way to avoid the morally abhorrent situations that act utilitarianism seems, on occasion, to prescribe.

David Hume, writing in *Enquiries Concerning Human Understanding and Concerning the Principles of Morals,* first published in 1751, expresses a rule utilitarian view of justice.

Hume argued that acts are judged to be right because they are found to be useful or agreeable to ourselves or others.(Douglas, C. 1897 Pg xix) He linked justice primarily to property. (Ryan, A 1993. Pg11)

> "Public utility requires that property should be regulated by general inflexible rules; and though such rules are adopted as best serve the same end of public utility, it is impossible for them to prevent all particular hardships or make beneficial consequences result from each individual case. It is sufficient, if the whole plan or scheme be necessary to the support of civil society, and if the balance of good, in the main, do thereby preponderate much above that of evil."
>
> (Hume, D. 1751. Pgs 47-48)

In the next paragraph he notes that man, if acting alone would often act contrary to the rules.

> "...Did all his views terminate in the consequence of each act of his own, his benevolence and humanity as well as his self love might often prescribe to him measures of conduct very different from those which are agreeable to the strict rules of right and justice"
>
> (Ibid Pg. 48)

Mill writing almost a century after Hume gives a systematic and detailed account of a utilitarian conception of justice in Chapter 5 of *Utilitarianism* entitled "On the connexion between Justice and Utility." He begins his account of justice by first examining commonly accepted notions of injustice and then goes on to demonstrate just how many different interpretations of justice and injustice exist. Some of the examples he uses are that communists regard just distribution as meaning exact equality, while others believe justice is done when goods are distributed according to need. Yet others believe "those who work harder or who produce more or whose services are more valuable to the community" can justly claim a greater share, "and the sense of natural justice may be plausibly appealed to on behalf of every one of these opinions". He sums up this confusion by saying:-

> "Among so many diverse applications of the term justice, it is a matter of some difficulty to seize the mental link which holds them together, and on which the moral sentiment adhering to the term essentially depends."
>
> (Mill, J. S. 1871. Pg 169)

Mill proceeds to attempt to define the *concept* of justice before elaborating his *conception* of justice. His argument is lengthy and convoluted and I shall thus attempt to briefly summarise, his main points.

Ethical writers, according to Mill, divide moral duties into two classes. The first are duties of "perfect obligation" and the second of "imperfect obligation". Duties of imperfect obligation are those in which "though the act is obligatory the particular occasions for performing it are left to our choice." (Ibid Pg. 174) Examples given are those of charity or beneficences. Duties of perfect obligation, on the other hand, are those duties "in virtue of which a correlative right resides in some person or persons". This distinction between duties for which there are no correlative rights, i.e. we are not compelled to do them, although it would be morally worthy to do them and those for which there are correlative rights, coincide exactly "with the distinction that exists between justice and the other obligations of society." (Ibid Pg. 174) Justice involves the idea of personal right or claim that can be made on another person or group of persons. "Justice implies something which is not only right to do and wrong not to do, but which some individual person can claim from us as his moral right. No one has a moral right to our generosity or beneficence." (Ibid Pg. 175)

Mill goes on to state that another two essential elements in the sentiment of justice are firstly a desire to punish a person who has done harm or violated a right and secondly the knowledge or belief that there is a definite person or group of persons who have been harmed. He then goes on to claim that when we feel our sense of justice outraged, although we may be concerned with an individual case, unless we can see that the interests of society as a whole are involved, we are not consciously just or acting justly. Because this step in Mill's argument is crucial to its coherence it is best to hear what he has to say.

> " ....but a person whose resentment is really a moral feeling, that is, who considers whether an act is blameable before he allows himself to

> resent it- such a person, though he may not say expressly to himself that he is standing up for the interest of society, certainly does feel he is asserting a rule which is for the benefit of others as well as for his own. If he is not feeling this – if he is regarding the act solely as it is effecting him individually -- he is not consciously just; he is not concerning himself about the justice of his actions. This is admitted even by anti-utilitarian moralists deciding on the morality of the act."
>
> (Ibid Pg 170)

Mill cites Kant's categorical imperative to support this assertion.

Thus the concept of justice "supposes two things:- a rule of conduct and a sentiment which sanctions the rule". The rule of conduct must be "common to all mankind and intended for their good". The sentiment is a desire that those who break the rule, will be punished. (Ibid Pg. 180) Mill reaches the climax of his argument by stating that to "have a right, means to have something which society ought to defend one in the possession of." What is the justification for the 'ought' ? Why should that right be defended by society? Mill's answer is " I can give (him) no other reason than general utility". He goes on to declare that the specific kind of utility involved is that of security.

> "Nearly all other earthly benefits are needed by one person, not needed by another, and many of them can if necessary be cheerfully forgone or replaced by something else; but security no human being can possibly do without.....since nothing but the gratification of the instant could be of any worth to us, if we can be deprived of everything the next instant, by whoever was momentarily stronger than ourselves."
>
> (Ibid Pg. 182)

Personal rights are only justified if by upholding them the principle of utility i.e. the well-being of society as a whole will be maximised and in particular that security in terms of property and personal liberty will be maximised.

Mill goes on to comment that utility is regarded by some as an 'uncertain standard' whereas justice is 'immutable' and independent of the fluctuations of opinion. He then sets out to show that the opposite is in fact true. He does this by a detailed discussion of

different interpretations of justice regarding punishment, remuneration for work and tax laws. He concluded that there are many preferred standards of justice, that "social utility alone can decide the preference".(Ibid Pg. 189)

The crux and conclusion of Mill's argument is summed up by ...

> "While I dispute the pretensions on any theory of justice not grounded on utility, I account the justice which is grounded on utility to be the chief part, and incomparably the most sacred and binding part, of all, morality. Justice is a name for certain classes of moral rules which concern the essentials of human well-being more nearly and are therefore of more absolute obligation than any other rules for the guidance of life; and the notion which we have found to be of the essence of the idea of justice, that of a right residing in an individual, implies and testifies to this more binding obligation.
>
> The moral rules which forbid mankind to hurt one another (in which we must never forget to include wrongful interference with each other's freedoms) are more vital to human well-being than any other maxims."
>
> (Mill, J.S. 1871. Pg 1991)

Thus a just action is one which maximises social utility. Rules that protect individuals from harming each other in any way, including harm to individual liberty, maximise social utility and are just. Rights are claims that can be made against another person, or persons, and are justifiable only if they result in the fulfilment of the principle of utility.

Utilitarianism has been severely criticized by several prominent moral philosophers. W. D. Ross, in *The Right and the Good*, states that utilitarianism "seems to simplify unduly, our relations to our fellows" He goes on to elaborate :

> "It says in effect, that the only morally significant relation that my neighbour stands to me, is that of being possible beneficiaries of my action. They do stand in this relation to me, and this relation is morally significant. But they may also stand to me in the relation of promisee to promiser, of creditor to debtor, of wife to husband, of child to parent, of friend to friend, of fellow

> countryman to fellow countryman and the like, and each of these relations, is the foundation of a prima-facie duty, which is more or less incumbent on me, according to the circumstances of the case."
>
> (Ross, W. D. 1930. Pg 89)

Ross discusses a list of duties, each resting on morally significant circumstances, e.g. duties of fidelity, duties of reparation, duties of gratitude, duties of beneficence, duties of self-improvement and duties of non-malificence. Utilitarianism ignores, or does not do justice to the concept of duty. (Ross, W. D. 1930. Pg 90)

Another critic of utilitarianism is John Rawls. In *A Theory of Justice,* which stands in direct opposition to utilitarianism, he states that a "principle that may require lesser life prospects for some, simply for the sake of greater life prospects for others", is unlikely to be adopted by any rational man, concerned with his own interests, as a principle on which to base a system of social justice.

> "In the absence of strong and lasting benevolent impulses, a rational man would not accept a basic structure, merely because it maximises the algebraic sum of advantages, irrespective of the permanent effects it has on his own basic rights and interests."
>
> (Rawls, J. 1972. Pg 14)

Rawls' theory of justice and his views on utilitarianism will be further expanded in Chapter 6.

A utilitarian system of social justice, requires that the good in society as a whole, be maximised, even if this ultimately means that a few are disadvantaged in order to benefit the majority and even if that few, are the already disadvantaged poor. Beauchamp and Childress illustrate this feature of utilitarianism, with an example published in the *New England Journal of Medicine* (296) 1977. Pg 716-721. Researchers, seeking the most cost effective way of controlling hypertension in an American population, came to the conclusion, that in a community with limited resources, it would be more cost effective to concentrate on improving compliance and treatment of the already established hypertensive sufferers, rather than to extend the program to the poorer, undiagnosed sectors of the population. The investigators were bothered by the apparent injustice of

their findings, but nevertheless, recommended what they described, as a utilitarian allocation of resources. (Beauchamp, T. Childress, J. 1994. Pg 55)

Robin Barrow, a proponent of utilitarianism takes up this criticism by actually questioning whether it is correct to interpret utilitarianism as wanting the greatest happiness for the greatest number. He says ideally everybody's happiness should be maximised equally and prefers a formula that builds in the "assumption that nobody's claim to happiness can simply be ignored, though in an imperfect world a policy may have to be adopted that brings little happiness to particular individuals." (Barrow, R. 1982. Pg 12) He goes on to suggest that this could be done by "adopting a form of wording that owes something to John Rawls' principle of justice", i.e. that in practice one should aim at the greatest happiness for the greatest number, provided that no policy is adopted that ignores the claims to happiness of any individual or would make some happier at the expense of others." Barrow seems quite happy that this qualification "is sufficient to dispose of the charge that utilitarianism would sanction the sacrifice of some in the interests of others". (Ibid Pg. 20) However, it seems to me he has played right into John Rawls' hands, so to speak, and actually crossed the line from a utilitarian to a Rawlsian point of view! By needing to add a 'side constraint,' he is in fact emphasizing what many find so problematic with the principle of utility in general and utilitarian justice in particular .i.e. that the communal greater good can on occasion be to the detriment of individual or minority good.

Another criticism or weakness of utilitarianism, as mentioned earlier, is that it may permit or even obligate actions which, as judged by the common morality are considered immoral, e.g. torture of a few in order to save the lives of many. Conflict arises, because the choices we face in such a situation, are not just between possible outcomes. As Thomas Nagel states, in *War and Massacre* "They are also choices between alternative pathways or measures to be taken. When one of the choices is to do terrible things to another person, the problem is fundamentally altered: it is no longer merely a question, of which outcome would be worse." (Nagel, T. 1979. Pg 52) It is difficult to ignore the fact that in many situations, the action itself, not just the outcome, is morally relevant.

A further criticism of utilitarianism, is that it is a moral theory that demands too much from the individual. Because the principle of utility requires the production of maximum value, there appears to be no clear line drawn between acts that are obligatory and those that our

moral intuition indicates are supererogatory i.e. requiring more then what would normally be accepted of one, by common moral standards. Samuel Scheffler comments:

> "Utilitarianism is an excessively demanding theory, because it seems to require, that one neglect or postpone ones own pursuits, whenever one could produce even slightly more good in some or other way. Nor, it seems is this an empty demand, for in a world as full of human suffering and misery as this one, only those with an extraordinary degree of moral self confidence, will be prepared to proclaim that there is no possible way they could do any more good for the world, then by doing exactly what they are already doing."
>
> (Scheffler, S. 1988. Pg 3)

The preceding evaluation seems to have left the general theory of utilitarianism in tatters. However, the principle of utility and a utilitarian theory of justice does, according to theorists like Tom Beauchamp and others, have a valuable role to play in the development of public policy. Utilitarianism calls for an objective, impartial evaluation of everyone's interests and decision making, that will ultimately increase the goods received by all parties. This principle is often an acceptable guide to the making of public policy e.g. health policy even if one does not fully agree with the utilitarian standpoint. It is important to acknowledge that utilitarianism is both a consequence and a beneficence based theory. Morality is viewed as a means of advancing welfare, including public welfare. (Beauchamp, T. Childress, J. 1994 Pg 55)

The role of a utilitarian approach to justice in the formation of health policy and in particular the implications of this approach to the South African HIV/AIDS dilemma will be considered in the next Chapter.

Chapter 5

Utilitarian Justice and the HIV/AIDS Epidemic in South Africa.

In the preceding chapter I examined utilitarianism as a theory of justice and considered its strengths and pitfalls. I now need to consider whether a utilitarian approach to justice can adequately address current problems in health care, caused particularly by the rampant HIV/AIDS epidemic in South Africa. This discussion is obviously based on the assumption that resources available for health care are limited and that decisions have to be made regarding both the macro-allocation and micro-allocation of funds, i.e., what proportion of the overall budget should be allocated to health care, and of that allocation, how much to prevention and promotion of health, and how much to personal medical services. The utilitarian theory of justice focuses entirely on outcomes, not on other considerations like need or desert. The correct allocation is that which produces the outcome that maximizes aggregate social welfare.

The aim (or stated aim) of most governments and certainly the current South African government, is to maximize the overall well-being of society. This seems a noble and just cause and appears to be compatible at first glance with a utilitarian approach to justice. It is undoubtedly a fact that utilitarian considerations and calculations form the basis of much public policy and can on scrutiny be seen to be the motivating principle behind several polices currently in place in terms of the State's approach to the HIV/AIDS epidemic. This assertion will be expanded upon and justified later in the discussion.

Many bio-ethicists believe that utilitarianism has a "legitimate role to play, if not an exclusive role, in the formation of health policy". (Beauchamp, T. Childress, J. 1994. Pg 336) However, this somewhat wry comment by Max Charlesworth is worth noting:-

> "At a time when in mainstream theoretical ethics, utilitarianism has been stringently criticized and is now in considerable disarray as an ethical theory, it has become the darling of the health care resource allocation experts. The late Cambridge philosopher C.D. Broad once remarked that all good philosophical heresies go to America when they die, but whether or not that is true, utilitarianism has certainly found a home among health care economists, planners and bureaucrats, even if it has fallen out of favour with many professional moral philosophers."

(Charlesworth, M. 1993. Pg 112)

Utilitarianism is, as mentioned before, a teleological moral theory. This means the 'good' is defined independently from the 'right' and the 'right' is defined as that which maximizes the 'good'. The 'good' is defined as pleasure, happiness, absence of pain, satisfaction, all collectively labelled 'utility'. (Buchanan, A. 1991. Pg 5) Thus the right decisions either at an institutional, or policy level (macro decisions) or on a more individual level, possibly involving choosing between patients (micro level) is that, which when everybody involved is taken into consideration, will maximize the overall or aggregate good. This of course implies that it is possible to calculate or add up different 'satisfactions' where 'satisfaction' may mean any of a number of things; relief from long-term moderate chronic pain, short-term acute severe pain, mental anxiety, etc.

One of the most challenging questions asked when discussing health care and justice, is the question of 'rights'. Is there a right to health care and if so, exactly what is that right, or to what level of health care does that right extend? The South African Constitution states somewhat ambiguously, that adults have a "right of access to health care", and children have a "right to health care". (In fact, all children under the age of six do have a legal right to free health care in South Africa. Theoretically this should mean they have a right to have all their health care needs met.) Under a utilitarian system of social justice, rights are purely derivative, not independently acknowledged. Thus one has a right to health care only if it can be demonstrated that the observance of the 'right' will result in a maximization of aggregate social welfare or utility. "A utilitarian system of derivative rights will pick out certain goods as those which make an especially large contribution to the maximization of utility. If empirical research indicates that certain services will maximize utility and that a system of institutional arrangements would include such services, and that such services can best be assured if they are accorded the status of a right, with all that implies, including coercive sanctions, then according to utilitarianism there is such a derivative right". (Buchanan, A. 1993. Pg 14-15)

How then, would a group of utilitarian state health care policy makers approach the current HIV/AIDS crisis in South Africa? I have established that there is no independent right to a health care service, only that which utility dictates. Furthermore, it is clear that when determining what is the right policy or action "the total profit and loss to all affected by that action" or policy, must be calculated. (Day, J. 1990. Pg 37) This is a daunting task indeed

and in reality probably proceeds by a process of estimation and speculation, rather than actuarial calculation. All possible consequences, good or bad, affecting the individual and society in general must be assessed. An action would be justified on utilitarian grounds if the "greatest possible balance of pleasure over pain would be achieved, for all affected by the action, even if the greatly increased benefit to the vast majority entailed the total neglect of a suffering minority". (Ibid Pg 37) Herein lies 'the rub' of utilitarianism.

A utilitarian approach to health care thus seems to necessitate first and foremost, a great deal of empirical research before any major health policy decisions can be made. This is emphasized over and over again by Buchanan in his discussion on utilitarianism and health care. (Buchanan, A. 1993. Pgs 3-21) "The issues of priority within health care, as well as that of priorities between health care and other goods must be settled by empirical research." (Ibid Pg 15) This presents our utilitarian state policy makers with an immediate and almost insurmountable problem, that of information gathering in the midst of a steadily accelerating crisis. In order to allocate resources and formulate policy decisions one has to know which services and strategies will produce the best outcome in terms of aggregate utility. In order to answer these questions and make the necessary utility calculations, resources of time and money need to be spent on various forms of research; economic, clinical, and epidemiological. Only then can the state policy makers decide whether utility will be maximized for instance, by spending money on 'HIV-prevention' strategies, as opposed to 'rescue' strategies (e.g. ART). This approach is problematic on several accounts.

Firstly and obviously it is a time consuming and costly process. The HIV/AIDS epidemic unfortunately continues steadily to gather momentum. It will not 'stand still' while information is gathered to facilitate policy making. This approach can lead to the accusation (which has been levelled at the Department of Health by academics and clinicians) that government is simply 'stalling' or 'buying time' before implementing what many see as morally just policies, although perhaps not on utilitarian grounds. One example given to illustrate this position, is the Mother-to-child Transmission Pilot Sites for Nevirapine use. Many of these sites have been using Nevirapine to prevent HIV transmission from mother to child for at least two years and results from these pilot studies indicate that it is an effective and safe and appears to maximize utility. However it has taken legal action and a Constitutional Court ruling to get a policy decision to extend Nevirapine availability, nationally. This policy is as yet not widely implemented.

Another problem with basing health policy decisions on empirical research aimed at calculating maximal utility is that there is a paucity of accurate statistical information available. The national epidemiological surveillance program is the annual Ante-Natal HIV and Syphilis Surveillance Study. These statistics and death notification statistics alone cannot be used to answer the countless questions posed, as to which are the most effective (i.e. maximal utility) management strategies. Further research, especially epidemiological research, raises questions about informed consent, privacy and autonomy. A strictly utilitarian approach does not recognize any rights other than those derived from utility. Thus if an epidemiological study was needed to guide the formation of management policy, but this study would infringe on rights to privacy and informed consent, then the utilitarian would ignore rights of autonomy and privacy because they don't in fact exist in this scheme of things, (unless they can be shown to always maximize utility), and conduct the study anyway. I believe therefore that the utilitarian health policy maker would in all likelihood, before anything else, make HIV/AIDS a notifiable condition. A huge amount of additional accurate information about the epidemic and its effects on society would become available and undoubtedly clarify many of the issues surrounding various prevention and management strategies.

However, making HIV/AIDS a notifiable disease infringes the broadly accepted rights of autonomy, privacy and confidentiality. No one can deny that in South Africa today sufferers are still the victims of overwhelming prejudice and stigmatisation. The ever-increasing number of deaths of young public figures both in government and the entertainment industry from 'pneumonia' or a in recent years, bears testimony to this assertion. Moreover, as I have discussed in Chapter 2, women in South Africa are particularly adversely affected by this epidemic. They are often vulnerable to condemnation, and possible abandonment both from their communities and their families, if their HIV status becomes known. It is for these reasons, and because of the principle of 'respect for persons' i.e. individual identified persons, that I cannot support the call to make HIV/AIDS a notifiable disease, even if it is justifiable (which I believe it probably is) on utilitarian grounds.

A third problem with formulating heath policy decisions on utility calculations based on various forms of empirical research, is that these calculations are notoriously difficult to make and often require comparisons between values that are not strictly comparable. Is

overall social utility or satisfaction maximized by preventing babies from getting HIV infection from their mothers only to be orphaned at a later stage, or by allowing the babies to contract the disease and die in a similar time frame to their mothers? Can calculations of utility ever answer such questions? Surely the Kantian notion of the moral dignity and worth of every human life is a more suitable pointer in such circumstances? I certainly will hold that it is.

The above problems are effectively summarized by Charlesworth:

> "Utilitarian approaches in health care resource allocation are theoretically concerned with getting the best outcomes for health dollars spent and there is of course nothing wrong with that laudable aim, so long as it is concerned with means to already decided ends, or goals themselves and not with the determination of the ends or goals themselves. For example, we cannot plausibly show on utilitarian principles, that we should respect the lives of gravely disabled newborn infants. But given that we have decided, on non-utilitarian grounds, that we should respect the lives of disabled newborns, we can show which are the most effective ways of expressing that respect in a given set of circumstances."
>
> (Charlesworth, M. 1993. Pg 112)

In other words, Charlesworth believes that other, non-utilitarian moral criteria should be used to determine desired goals or outcomes and once these goals are determined, a utilitarian approach may help decide which of a number of options, would be the best way to achieve the predetermined goal. So having decided that it is morally correct (on non-utilitarian grounds) to attempt to prevent the transmission of HIV from mother to baby, it may then be helpful to determine by a utilitarian approach, which is the most effective means of achieving this outcome. This of course is really contrary to strict utilitarian theory of justice, because primary goals are established using non-utilitarian principles.

I have emphasized the point that health policy decisions based on calculations of overall utility, or maximization of well-being, are difficult because of the plurality of goods being calculated. Various tools have been developed by health economists to facilitate these calculations and comparisons: e.g. Cost Benefit Analysis, Cost Effective Analysis, and Quality Adjusted Life Years (QALYs).

QALYs in particular are an attempt to bring the two dimensions of length of life and quality of life into a single framework for evaluation and comparison. Costs can be examined relative to the QALYs provided by different treatments, and efficiency and effectiveness can be determined. (Beauchamp, T. Childress, J. 1994. Pg 308) The utilitarian policy maker would favour an intervention that gets the most QALYs per monetary unit spent.

Basing a health care system on a policy that maximizes QALYs has been criticized by many commentators especially John Harris. He believes the use of the QALYs approach to resource allocation biases the health care system to favour the young over the old, as they have more life years to gain from treatment. This may however, give some support for the use of QALYs within the context of HIV/AIDS epidemic because more young people are affected than older people. However QALYs favour conditions that are cheap to treat and "not only discriminate against conditions which are initially expensive to treat, but also against groups of citizens identified by their condition, for example AIDS patients or cancer patients." (Harris, J. 1998. Pg 296) Hence the use of QALYs may well establish that it is more cost effective to spend a finite amount of money 'X', on providing prophylaxis to HIV positive individuals for opportunistic infections, rather than providing Anti Retroviral Treatment to those HIV positive individuals who are in the process of developing AIDS. This policy is in fact currently in place and has been justified on the basis of cost effectiveness. (See Department of Health Discussion Paper. Health Summit 2001. Dr Nono Simelala. "HIV/AIDS and TB; The dual epidemic and its challenges"). It has been extensively criticized by the South African medical profession, (including the South African Medical Association; See SAMJ Sept 2002 Pg 672-673) and civil society[1] who believe that a principled decision to provide Anti-Retroviral treatment to all AIDS patients who need it should be made on moral grounds (e.g., respect of persons, obligations of rescue and beneficence, etc.) and not on utilitarian grounds. Once this 'end' has been established and accepted, then utilitarian considerations may be brought in to decide the most cost-effective way of realizing it.

A utilitarian approach to health care would first need to determine on a macro economic level how great a portion of the overall state budget needs to be allocated to health care, as opposed to other primary goods. The maximization of overall social welfare may mean that even in the light of the HIV/AIDS epidemic in fact more money needs to be spent on basic needs such as water, sanitation and housing rather than on personal health care

services. As stated before, empirical research needs to attempt to determine these answers even though, as Robin Barrow says, "utilitarianism is not and does not purport to be a moral Geiger counter that will enable one to read off the right action. It is an attempt to explain what makes actions right or wrong." (Barrow, R. 1982. Pg 18)

Once decisions have been made as to how much of the overall budget should be spent on health care, further decisions need to be made on how this budget must be divided. How much needs to be spent particularly on addressing the HIV/AIDS crisis and how much on addressing other health care needs? As the HIV epidemic affects an ever increasing proportion of the population, so one would feel that a utilitarian policy maker would, in an attempt to maximize social well-being, deflect an ever increasing proportion of funds to addressing this problem. This of course returns us to the question of how our society ranks health care for HIV/AIDS as a primary good. What priority does it hold or what contribution will it make to the maximization of social utility? Only if it is regarded as a primary good of high priority, will adequate health care for HIV/AIDS become a derivative right from a utilitarian perspective. However it seems reasonable to assume that if 4.7 million South Africans are already HIV positive (more than 10% of the total population including children and the elderly) and will in the near future experience deteriorating health and ultimately full blown AIDS and death, then a just and honest utilitarian policy maker must allocate a very significant proportion of the overall budget to addressing this problem. Even if it means withdrawing funds already allocated to other areas e.g. the military budget.

After allocating a portion of the total budget to the health budget and a proportion of that to address the HIV/AIDS crisis specifically, it still remains to be determined how this crisis should be addressed in order to maximize utility. On what programmes or projects should these funds be spent? It is generally accepted that a utilitarian health policy will firstly prioritize prevention strategies, rather than curative strategies, (Buchanan, A. 1981. Pg 16; Childress, J. 1981. Pg 142) and secondly prioritize the treatment of diseases that are cheap to cure rather than expensive. (Wikler, D. Marchand, S. 1998. Pg 311; Kopelman, L. 1999. Pg 400; Harris, J. 1998. Pg 296) The current South African HIV/AIDS policy, in fact appears to live up to utilitarian expectations. A paper discussing priority setting for the HIV/AIDS epidemic released by the Department of Health at its Health Summit 2001 emphasizes prevention strategies, especially condom use and the treatment of sexually transmitted infections like syphilis and gonorrhoea that increase the spread of HIV/AIDS. Emphasis is also placed on treating co-morbid conditions such as TB, for which there is

already a well-established health structure in place. Another area that is attracting increasing attention and funding is "Home Based Care", where patients who now have AIDS are cared for in a home environment. Dr Nono Simelela, the chief Director for the Department of Health HIV/AIDS, STIS and TB programme writes:

> "No sector of South African Society will escape the impact of HIV/AIDS. The health sector, however, will feel the brunt of the epidemic. It is clear that the formal health system will not be able to cope with the increasing demands of those infected with HIV and AIDS. The answer is not to wait for the system to collapse under pressure. What is required is a re-thinking of how best to support and extend community-based care and support for those who are infected and affected. Government at national, provincial and local level has an important role to play in redesigning health and social support systems to allow for the establishment of what is commonly termed home based care."
>
> (Simelela, N. 2001. Pg 1-2)

Unfortunately the term "home based care" is ambiguous and open to several interpretations. The most widely accepted interpretation is that home based care is roughly equivalent to a hospice-type situation where palliative and supportive care is given to terminally ill AIDS suffers. However, patients with AIDS suffer from sequential opportunistic infections, usually readily diagnosable and treatable, although at considerable cost and often in a hospital based environment. Anti-retroviral drug regimes target the HI virus and often result in immune reconstitution and a marked decrease in opportunistic infections, and other AIDS-related symptoms. These interventions are very costly and a utilitarian health policy can probably show that more Quality Adjusted Life Years (QALYs) can be bought per monetary unit by prevention and home base care programmes than by expensive treatment regimes. At the time of writing this dissertation Anti-Retroviral Drugs are not available in State health institutions and adequate treatment of many opportunistic infections occurs only at academic institutions. Throughout the remainder of the country, and especially in rural areas patients with opportunistic infections are treated inadequately or symptomatically. A common example is the widespread use of oral nystatin drops, (sometimes even Gentian Violet) for the treatment of intractable oro-pharyngeal and oesophageal candidiasis; a very common and distressing problem in patients with AIDS. This often ineffective medication is given, because the expensive effective systemic treatment is simply not available at most primary health care clinics.

Primary health care workers must do the best they can with available resources. (Recently a pharmaceutical company has made this medication available to the State free of charge, as a beneficence based response to a perceived dire need.)

One of the problems with a strictly utilitarian approach to health care financing and policy determination is articulated by Childress: "effectiveness and efficiency, or utility, are not the only relevant standards for evaluating policies of allocation of resources within health care." (Childress, J. 1981. Pg 142) As Charlesworth puts it, "All human acts or policies have consequences or outcomes, but most of them do not have quantifiable and reasonable outcomes with a dollar sign in front of them, which can be compared with and measured against other acts and policies, and calculated as being 'better' or 'worse' than the latter." (Charlesworth, M. 1993. Pg 114) The value of buying sufficient time for HIV positive mothers to see their children grow up to at least semi-independence, by treating those mothers with Anti-Retroviral medication is difficult to calculate and many would claim it is beyond calculation.

Another concept that needs to be discussed here is the concept of 'social utility' ;used in this context to mean the 'social value of a life'. Should utilitarian allocations particularly at a 'micro' level be made predominantly on grounds of 'medical utility' or should 'social utility' also be considered? Nicholas Rescher, in an oft-quoted, but obviously controversial paper entitled "The Allocation of Exotic Medical Lifesaving Therapy" published in *Ethics* in 1969 argues that social value is a very important factor when deciding who should get access to a scarce resource. He divides social value into three areas which he calls:-

- The family role factor
- The potential future-contributions factor, and
- The past services-rendered factor.

All three of these should be considered. So according to Rescher, a doctor and researcher with children, should get access to a scarce resource, e.g. a kidney for transplant, before a middle-aged bachelor postal clerk. Many would intuitively regard this approach as discriminatory, but a utilitarian policy maker, in the context of the current HIV/AIDS crisis in South Africa, may well be justified in assessing that utilitarian justice would best be served if a scarce resource like HAART (Highly-active Anti-Retroviral Treatment) would be made available first to HIV positive health care workers so that they remain well enough to care for the rest of the population. The utilitarian concept of 'triage' in a crisis could also be

used to justify this decision. However, within the South African context, with its recent apartheid dominated past, treatment allocations based on such discriminatory considerations as proposed by Rescher, seem particularly distasteful.

As discussed earlier a valid utilitarian decision needs to be based on empirical research that attempts to calculate objectively, the overall aggregate welfare or well-being. Without this information at hand one can only really speculate on how a utilitarian health care policy maker would address some of the challenges posed by the HIV/AIDS epidemic. However, this speculation is an interesting exercise and I shall thus take the liberty of pursuing it. Would a purely utilitarian health care system advocate involuntary HIV testing in certain instances? I think it may well do so, especially if patients are being considered for expensive elective surgery or admission to an Intensive Care Unit with limited bed availability. Perhaps applicants for state sponsored educational positions like medical school or teacher training college may also be subjected to involuntary HIV testing on the grounds that society's interests would best be served by ensuring that only HIV-negative students are accepted into such institutions. Rights of autonomy, freedom of choice, privacy and confidentiality may all, under certain circumstances, be overridden in a utilitarian system that only recognizes those rights that are derived from actions that maximize utility.

In conclusion one must ask the question whether or not a utilitarian theory of distributive justice has any positive role to play in determining a just health care policy for South African society in the grip of a devastating HIV/AIDS epidemic. I concur with Charlesworth who believes that "utilitarianism has not been able to provide a plausible account of distributive justice". He goes on to state …

> "For the utilitarian a just act or policy is one which produces, on balance, quantifiably greater benefits for the maximum number of people. It may be that a minority of people are gravely disadvantaged by the policy but these disadvantages or costs are outweighed by the benefits to the majority. ……. The utilitarian strategy does not take into account the distribution of benefits and harms. It merely examines net aggregate benefits, which implies that if enough people receive benefits, it is plausible that even more enormous harm to a small number will be outweighed by the aggregate benefit to the masses."

(Charlesworth, M. 1993. Pg 116)

The current HIV/AIDS health care policy is largely aimed at ensuring that the uninfected South African population remains uninfected. Those unfortunates who are already HIV positive now represent the "gravely disadvantaged" although they are rapidly becoming a large, rather than a small, minority.

Notes

1. The Treatment Action Campaign, widely known as TAC, is a very active, vociferous and forthright campaigner for the rights of people living with HIV and especially for the availability of adequate medication including ART. The AIDS Law Project is another similar organisation.

Chapter 6

An Egalitarian Theory of Justice : John Rawls' "Justice as Fairness"

John Rawls' major work, *A Theory of Justice* (1971) has, since its publication, become the platform from which any discussion or debate on justice is launched. (Campbell, T. 1988. Pg. 66) It has been the subject of countless reviews and commentaries. His ideas have influenced several spheres beyond his original stated intentions; health care reform, being one such example. In this chapter I shall briefly discuss his theory and attempt to give a concise summary of its most important aspects; a difficult task as the original work numbered in excess of 500 pages and has been described by one critic as a "baroque complexity". (Wolff, R. 1977. Pg 8) I shall conclude by discussing some criticisms of his theory, as well as illuminating its strengths. In the next chapter I shall discuss the implications of Rawls' 'Theory of Justice' or 'Justice as Fairness', as he calls it, for health care policy and particularly its application to the management of South Africa's HIV/AIDS epidemic. It is important to note here however, that Rawls himself did not extrapolate his theory to health care. This has been done by other authors, most particularly Norman Daniels. (Daniels, N. 1985.)

Rawls's theory is a social contract theory. A social contract sketches a hypothetical situation in which members of a society, (or potential society) reach an agreement or contract regarding basic principles or rules by which they will establish their society or political system. An obligation to conform to the agreement is obviously part of the contract.

This social contract can be used to determine which rights and duties will be recognized and binding on citizens, and to establish the "grounds of social, political and legal obligation". (Campbell, T. 1988. Pg 67) These agreements are reached in a hypothetical pre-social or pre-political state of affairs. In reality societies already exist, with established systems of politics and justice already in place. A contract theory however, asks us to imagine that these systems are as yet non-existent. The resulting contract or theory can theoretically, then be used as a tool for political or judicial reform. An argument could then be made that this contract represents the just basis for determining what norms and rules of conduct should be established, to govern just social institutions. Rawls' theory is just such an argument. It is not the first social contract theory ever postulated. This method of

thinking was fairly common in philosophical and political writings of the enlightenment period.[1]

Rawls' 'Theory of Justice', is generally described as an egalitarian theory, although some critics consider it 'relatively' egalitarian, as opposed to 'true' or 'strict' egalitarian theories. Strict egalitarian means strict equality. Rawls' version of egalitarianism accepts inequality in allocations so long as the "allocation redounds to the benefit of the worst off groups" (Veatch, R. 1998. Pg 457)

Rawls begins his theory by stating unequivocally that justice is of pivotal and paramount importance in social institutions.

> "Justice is the first virtue of social institutions, as truth is of systems of thought. A theory, however elegant, and economical must be rejected or revised if it is untrue, likewise laws and institutions, no matter how efficient and well arranged must be reformed or abolished if they are unjust".
>
> (Rawls, J. 1999. Pg 3)

He goes on to separate the concept of justice from a conception of justice, as discussed in Chapter 3. A concept of justice is a set of principles that "assign basic rights and duties" and "determine the proper distribution of benefits and burdens of social co-operation". (Ibid Pg 5) It is the task of A *Theory of Justice,* to determine what these principles are and to justify them, i.e. to define a particular conception of justice. These principles, Rawls stresses, are for determining the basic structure of society and of institutions, not for determining specific allocations, to specific individuals. (Ibid Pg 4)

In order to determine what basic principles of justice should be chosen, Rawls invites us the readers, to enter a hypothetical "original position" the purpose of which is to institute a fair procedure so that any principles agreed upon, will be just. The idea is that the hypothetical members of society will get together under a "veil of ignorance" and agree upon a set of principles that will be used to establish the basic functioning and mutual co-operation of their society. It is assumed that those involved in this process, do not know their own "place in the society, class position or social status, fortune in the distribution of natural assets and abilities, intelligence and strength, own conception of good, or even special features of psychology, such as aversion to risk, or liability to optimism or

pessimism." (Ibid Pg 118) They also do not know the particular circumstances of their own society, i.e. its economic, or political structure, level of wealth or type of civilization or culture. They even do not know to which generation they belong.

Behind the 'veil of ignorance' they are unable to use their own social position or talents to influence the choosing of principles, because when the veil is lifted they may either be among societies most fortunate or least fortunate. The members are therefore in a position of complete equality. The nature of this equality is grounded in the "Kantian notion of equality of persons as moral agents with equal moral worth". Each person in this original position has a "conception of the good", i.e. a knowledge of which personal goals are worth advancing and a sense of justice, or a group of ideas about what should count as fair social co-operation. (Campbell, T. 1988. Pg 76) Thus the principles chosen will be objective and to the advantage of the least privileged, as well as the most privileged members of society. Rawls likens this process to that of pure procedural justice, where fair procedure automatically produces a fair or just result. (Rawls, J. 1999. Pgs 74-75) Hence the name "justice as fairness."

Also the parties involved in the original position are described as rational and mutually disinterested, or not taking an interest (supporting or opposing) another's interest. The concept of rationality is used by Rawls in the sense used "in standard economic theory" as meaning "taking the most effective means to a given end". (Ibid Pg 12)

After establishing the "original position" from which the principles of justice will be worked out or bargained for, Rawls first launches into a criticism of utilitarianism. He wishes to establish clearly that the principle of utility would not be one of the principles chosen by rational men (and women) in the original position. I introduced his criticisms of utilitarianism in Chapter 4 but shall expand his argument slightly. The main idea of utilitarianism is that society is just if its major institutions are arranged to ensure "the greatest net balance of satisfaction summed over all the individuals belonging to it." (Ibid Pg 20) It is thus easy to conceive at first glance that the most plausible conception of justice is utilitarianism. Every man, who wishes to realize his own interests may accept a loss now in order to increase net gain, even if only fully realized, later. So, a society could adopt the same principle.

As Rawls explains:-

> "Since the principle of an individual is to advance as far as possible his own welfare and his own system of desires, the principle of society is to advance as far as possible, the welfare of the group to realize to the greatest extent the comprehensive system of desire, arrived at from the desires of its members. A society is properly arranged when its institutions maximize the net balance of satisfaction. The principle of choice for an association of men is interpreted as an extension of the principle of choice for one man. Social justice is the principle of rational prudence applied to an aggregative conception of the welfare of the group."
>
> (Rawls, J. 1999. Pg 21)

However, the crux of the matter, as Rawls sees it and his (and many others) chief objection to utilitarianism is, that it does not matter how the total satisfaction in society is distributed among individuals, any more than it matters how one man distributes his satisfaction over the span of his life. The correct or just distribution in either case is that which produces the maximum satisfaction. "Thus there is no reason in principle, why the greater gains of some, should not compensate for the lesser losses of others, or more importantly, why the violation of the liberty of a few might not be made right by the greater good shared by many." (Ibid Pg 23) Utilitarianism fuses the desires of many into one coherent system of desire, or as Rawls concludes at the end of Section 5 "Utilitarianism does not take seriously the distinction between persons." (Ibid Pg 24) This is Rawls' main objection to Utilitarianism. Consequently, according to Rawls, a rational man, wishing to further his own interests and operating from the 'original position' as described by Rawls, would not chose utilitarianism as a principle of justice on which to build the basic systems of co-operation in society.

Rawls has thus far defined the conditions of the 'original position' under which participants will chose the principles of justice and explained why the principle of utility would be excluded. The next step is to determine which actual principles would be chosen. He believes two principles would be chosen. He writes:-

"The first statement of the two principles reads as follows :-

First : Each person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for others.
Second : Social and economic inequalities are to be arranged so that they are both

- reasonably expected to be to everyone's advantage and
- attached to positions and offices equally open to all. " (Ibid Pg 53)

Rawls reiterates that these principles apply to the basic institutions of society, i.e. those institutions "that govern the assignment of rights and duties" (principle one) and those institutions that "regulate the distribution of social and economic advantages." (principle two)

Basic liberties are specifically documented by Rawls and include political liberty, freedom of speech and assembly, "liberty of conscience and freedom of thought", freedom of the person, which he defines as freedom from psychological oppression or physical assault, freedom to own personal property and freedom from " arbitrary arrest and seizure". These liberties are to be regarded as equal and are covered by the first principle.

The second principle applies to the way income or wealth is distributed in society and to the manner in which organizations or institutions are structured to allow for differences in positions of authority and responsibility and of course remuneration. Rawls further stipulates that these two principles are ordered, i.e. the first takes priority over the second. This means that one cannot justify an infringement of basic liberties by a position of increased economic social advantage. (Ibid Pg 54) The essential conception of 'Justice as Fairness" can be summarized by stating that:

> "all social values including liberty and opportunity, income and wealth, and the social bases of self respect, are to be distributed equally, unless an unequal distribution of any, or all of these values is to every one's advantage."
>
> (Ibid Pg 54)

Rawls first principle is fairly self-explanatory and I shall not elaborate further. However, the second principle contains two phrases " to every one's advantage" and "equally open to

all", that are acknowledged by Rawls as ambiguous and require further explication. This is in fact done by Rawls in great detail, using fairly complicated mathematical models and takes up much of the rest of the book. The details of his explanation and applications are obviously beyond the scope of this dissertation. However I shall discuss in more detail what has become widely and famously known as the "Difference Principle" and "Rule of Fair Opportunity" because this aspect of Rawls' theory has been applied specifically to theories of just health care, and will be the subject of the next chapter.

"Equally open" can, according to Rawls be interpreted as "Equality, as careers open to talents" or " Equality, as equality of fair opportunity". Rawls assumes a background of equal liberty, as determined by the first principle and a free-market economy. "Equality as careers open to talents" means that everyone has the same legal right of access to all advantaged social positions. However the initial distribution of talents and abilities, income or class position is determined by social circumstances and contingencies that may negatively influence one's ability to attain such a position. So, although a particular position is open to all, one's chance of accessing that position may well be much higher for someone born into a higher social class and afforded a private education, than someone not so advantaged by life's natural or social lottery. Rawls' second interpretation of 'equally open' adds to the " requirement of careers open to talents, the further condition of the principle of fair equality of opportunity." (ibid Pg 63) This means that positions must not only be open to everyone in a non-discriminatory manner but that everyone should have a fair opportunity at actually being appointed to such a position. In other words those who have a specific level of talent and ability and have an equal willingness to use or develop their talents, should have identical prospects of success *regardless of their initial place in the social system*. However, as Rawls points out, this concept or principle still seems to be lacking. Although compensation has been made for differences in social class, what about the natural distribution of talents, abilities or even disabilities; the outcome of "life's natural lottery"?

One's family circumstances can also be considered part of the natural lottery. He says, "Further more the principle of fair opportunity can be only imperfectly carried out, at least as long as some form of family exists. The extent to which natural capacities develop and reach fruition is affected by the kinds of social conditions and class attitudes existing. Even the willingness to make an effort, to try, and so to be deserving in the ordinary sense, is itself dependent upon happy family and social conditions." (Ibid. Pg 64) Intuitively a

principle of justice must recognize this fact and *attempt to compensate for the arbitrary allotment of life's natural lottery.* Rawls' 'Difference Principle' is his answer to the above problem.

The principle of 'fair equality of opportunity' must be combined with the 'difference principle'. The basic structure of society means that individual's life prospects are influenced by factors beyond their control, such as the social position or class they are born into, gender, natural ability or disability. A system of distributive justice must address these differences in life prospects. 'The Difference Principle' holds that

> "these differences are just, if and only if, the greater expectations of the more advantaged when playing a part in the working of the whole social system, improve the expectation of the least advantaged. The basic structure is just throughout when the advantages of the more fortunate promote the well-being of the least fortunate, that is, when a decrease in their advantages would make the least fortunate even worse off than they are. The basic structure is perfectly just when the prospects of the least fortunate are as great as they can be."
>
> (Rawls, J. 1986. Pg 81)

Any society consists of members occupying different positions of wealth, income and status. The difference principle says that these inequalities are just, only if, in the greater scheme of things, those at the bottom of the social scale would be in an even worse position if those higher up had less; e.g., less power, innovation, entrepreneurial skills etc. The difference principle is in fact an agreement to share the benefits of the arbitrary distribution of social position and talent, as well as the arbitrary handicaps, either physical, mental or circumstantial that are largely beyond our control. Those on whom the 'gods have smiled' may justly benefit from their good fortune, only if they improve the lot of those less fortunate. Rawls believes that the parties in the 'original position' as described, behind their veil of ignorance, in a position of complete fairness, would choose these two principles of justice because they would be seen to be in their best interests to do so.

In the remainder of *'A Theory of Justice'* Rawls elaborates further on these two basic principles, including their justification. He also attempts to demonstrate what forms the institutions of society need to take, in order to fulfil, or comply, with his 'Theory of Justice'.

Briefly his scheme translates into a basic social structure controlled by a just constitution which upholds the liberties provided for in the first principle and has a "legal order that is administered in accordance with the principles of legality, and liberty of conscience and freedom of thought are taken for granted." Government should provide equal education opportunities for all. It must also ensure "equality of opportunity in commercial ventures and in the free choice of occupation." Policing business behaviour and ensuring that positions and markets remain open to all, achieves this. "Lastly, there is a guarantee of a social minimum which the government meets by family allowances and specific payments in times of unemployment, or by a negative income tax."(Rawls, J. 1967. Pg 84) In order to maintain these institutions, Rawls sees the government as divided into four branches which he names the "allocation branch" which must keep the economy feasibly competitive, "the stabilization branch must strive to maintain reasonably full employment", the "transfer branch" which "establishes a social minimum" and finally a "distributive branch" which "must preserve an approximately just distribution of income and wealth over time by a system of inheritance and gift taxes and by raising revenue to cover the cost of public goods". (Rawls, J. 1967. Pgs 85-86)

As mentioned earlier Rawls has insisted on several occasions both in the book and in subsequent writings, that his theory is intended as principles of justice for the basic institutions of society, where that society is a constitutional democracy with a largely free market economy. The principles are not intended to determine specific allotments to specific individuals. Also Rawls himself has not extended or adapted this theory to health policy. Nevertheless, "Justice as Fairness" has been widely proclaimed as a landmark moral theory that provides a plausible and instinctively acceptable alternative to the deficiencies of utilitarianism. In fact Rawls uses the notion that his principles comply with our commonsense intuitions of justice and would be reached by a process of 'reflective equilibrium', to, in part, justify his choice of principles. (Campbell, T. 1988. Pg 73)

The concept of social justice is closely linked to the idea of addressing the needs of the least fortunate members of the society. Any adequate conception of justice must consider or account for the interests of the poverty stricken, the weak and the disabled or exploited members of the society, and one that does not, seems intuitively, to be deficient. One of the strengths of Rawls' theory is that it appears to combine the concept of moral agency, autonomy and freedom of choice with a sincere concern for less fortunate members of

society. It is this feature that makes it immediately compelling when considering theories of justice for a society such as post-apartheid South Africa, struggling with the effects of a devastating HIV epidemic. However, Rawls' theory has been extensively criticized by many authors who have attempted to show that its application may not in fact relieve the plight of the less fortunate, as it appears to promise on first inspection. Some of his critics are very harsh. For instance Robert Wolff says, in his book 'Understanding Rawls':-

> "The book gives every evidence of having been elaborately cross-referenced, unified and synthesized as though each element of the argument had been weighed in relation to the other; yet there are numerous serious inconsistencies and uncertainties that make it appear that Rawls could not make up his mind on some quite fundamental questions. The logical status of the claims in the book never become entirely clear, despite Rawls' manifest concern with matters of that sort. In many places he seems simply to admit that he has adjusted his premises to make them yield the conclusions he desires;....."
>
> (Wolff, R. 1977. Pg 3)

Many of the criticisms deal with details of his theory and its application to government and economy that are beyond the scope of my discussion. I will however now briefly outline some of the main points of criticism.

Churchill states in an article entitled 'Looking to Hume for Justice' that while Rawls and his 'health-policy interpreter', Norman Daniels, have been very influential among bioethicists and academics, this influence has not translated into any form of public or health care reform. One of the main reasons for this is that the 'original position' is too remote, "the price of becoming unbiased is too high and relevance is sacrificed in the bargain". He goes on to state his point quite clearly:-

> "Few of us are prone to think of the ideal setting of moral choice as one in which all the social and historical aspects of our lives are stripped away. Choosing as if we were disinterested, rational contractors, or as angelic beings, seems not only remote from our real concerns, but deprives us of those very tools and resources for choosing, that make our choices morally coherent."

(Churchill, L. 1999. Pg 356)

Churchill is writing within the context of justice and healthcare and believes that the "motivational remoteness" of the Rawls' contract position tends towards utopianism, which he says, quoting Thomas Nagel, is a view that ordinary people cannot be motivated to take seriously. In addition, he believes Rawls' aim to remove bias by the "veil of ignorance" may have the opposite effect of subverting bias and making it too difficult to examine critically. "Even when our motives are benign or admirable, the high altitude theorizing of the Rawlsian program, tends to make us blind to our motives, rather than engage them in the light of the day." (Churchill, L. 1999. Pg 357)

Apart from criticizing the 'original position' per sè, others have suggested that persons in the original position would in fact adopt the principle of average utility rather than Rawls' two principles. Rawls defines the principle of average utility as directing society to maximize not the total satisfaction or utility but the average utility per capita. Campbell believes it is "desperately ad hoc" of Rawls to rule out the adoption of this principle by insisting that rational, self-interested individuals would not be prepared to take the possible personal risks involved in accepting the principle of average utility as the basis for social choice in preference to the principles posed by Rawls. (Campbell, T. 1988. Pg 83)

Another criticism articulated by Campbell, is that the difference principle is not actually directed at the most needy and unfortunate, in society. Rawls persistently refers to the 'lowest represented man' as the one earning the lowest wage and does not refer to the unemployed, destitute or homeless, or the mentally or physically disabled. Likewise the members in the original position are all autonomous moral agents capable of mutual co-operation. There seems to be no voice representing those who cannot be independent moral agents for reasons of mental disability and the like. Rawls' model is designed to deal with the distribution of the benefits of society to which all members contribute. If non-contributors are represented in the original position then the basis for a bargained agreement is compromised, but to exclude them seems to run contrary to our entire common-sense notion of justice. On the other hand if the difference principle were to include not only the sickly worker but all those unable to work then society would become "one large hospital or welfare institution." (Campbell, T. 1988. Pgs 90-93)

Robert Veatch criticizes Rawls' theory for not being truly egalitarian. He says that according to Rawls if a practice can only improve the lot of the least well-off by increasing

inequality, it is not only permitted but required. (Veatch, R. 1998. Pg 45) Veatch uses an example of direct donation of transplant organs, as a basis for his argument, to demonstrate that Rawls' system can require inequalities that would be offensive to most people's intuitive notion of justice. The family of a Ku Klux Klan member, donates his organs to be used by a white patient only. If this condition is not fulfilled the organs are not available. Should the direct donation be accepted within the limits set by the family, or should it be rejected on principles of equality and non-discrimination and the organs lost? If it is accepted, no one is worse off and all those in the queue for the next organ donation, below the white person who receives the organs, move up a position, so therefore they are better off. On the surface the dispute appears to be between utilitarians who tolerate directed donation and egalitarians who are committed to the principle of equality and would rather sacrifice the organs, than contravene this principle of justice. However, according to Veatch the Rawlsian 'difference principle' also provides a support for directed donation because those below the recipient are better off and those above are in exactly the same position as they were. Thus tolerating discrimination on the base of race or religion is to the advantage of everyone worse off and to the disadvantage of no one. Thus Veatch believes the difference principle of justice leads to a significantly different conclusion from a true egalitarian account of justice and therefore must be called into question. His argument is developed further over subsequent pages. He concludes by making an additional criticism. "What is missing from the Rawlsian sense of justice is any notion of community solidarity. Some have such an empathy for their fellow humans, that they have a moral sense of revulsion at a lack of opportunities for equality regardless of whether they are among the best or worst off." (Veatch, R. 1998. Pg 467)

Finally Wolff criticizes Rawls for focussing exclusively on distribution rather than production and obscuring the real roots of distribution. He quotes Marx thus:-

"Any distribution, whatever the means of consumption, is only a distribution of the conditions of production themselves. The latter distribution, however, is a feature of the mode of production itself." (Wolff, R. 1977. Pg 210)

I certainly have not exhausted or even adequately explored the immense number of criticisms and critiques of Rawls' work. However the vast amount of critical literature bears testimony to the influence Rawls has had on political science and philosophy and the challenges to these disciplines his theory has posed, rather than indicating that Rawls is of little practical or theoretical use to debates around issues of social justice.

Rawls' theory of justice has been used extensively in bioethical literature as a basis for the development and reform of health care policy. Obviously it has its proponents and detractors. The adaptation of Rawls to justice in health care, will be the subject of the next chapter.

Notes

1. Social Contract Theory was first worked out in the 17th century. Examples are Thomas Hobbes, *Leviathan* 1690, John Locke *Two Treatises of Government* 1690 and Jean-Jacques Rousseau, *The Social Contract* 1762.

Chapter 7

Rawls Theory of "Justice as Fairness" and Health Care Policy for the HIV/AIDS Epidemic in South Africa

It is my task in this chapter to discuss the application of Rawls' Theory of Justice to the South African context and in particular to the arena of health care. As I have noted earlier, Rawls himself did not apply his theory to health care and excludes health and education from his list of "primary social goods." "Primary social goods are those that a rational person would want, to fulfil his chosen life plan -- liberty and opportunity, income and wealth and basic self-respect – and are to be distributed equally unless an unequal distribution of any or all of these goods is to the advantage of the least favoured." Other primary goods Rawls labels 'natural' goods and these are not covered by his distribution principle. These include "health and vigour, intelligence and imagination and are influenced by the basic structure, but not so directly under its control." (Rawls, J. 1999. Pg 54) (See also Daniels, N. 1985. Pg 45)

However other theorists have attempted to adapt Rawls theory of justice to health care. Ronald Green (1976) argues, according to Shelp, that health care can and ought to be considered a primary social good and thus governed by Rawls' distributive principles, because health and consequently health care, is not only a function of natural contingencies but is greatly influenced by medical technology and social decisions. Thus health care has instrumental value and contributes towards the fulfilment of one's life plan and therefore should fall under Rawls' distributive principle. (Shelp. E. 1981. Pg 217)

Green's approach is problematic on several accounts and I shall discuss these shortly. Subsequent to Green, Norman Daniels has become the chief and widely accepted interpreter of Rawls for health care policy, and his approach has been clearly stated in his books *Just Health Care* 1985 and *Benchmarks of Fairness for Health Care Reform*. 1996. (Daniels, Light and Caplan) He has also written numerous articles on this matter and is extensively quoted in bioethical literature pertaining to justice in health care. I find Daniels' approach to be particularly illuminating within the current South African context and will rely on him heavily to illustrate how "Justice as Fairness" could translate into health care policy for post-apartheid, HIV/AIDS affected, South Africa.

Before continuing with my discussions of Green and Daniels, I shall digress briefly. In 1987, during the darkest days of apartheid in South Africa, Charles Simkins wrote an article entitled "Democratic Liberalism and the Dilemmas of Equality." In it he appealed for a Rawlsian approach to justice in South Africa and in particular to the development of a South African Constitution. The central idea of "equality of opportunity" is at the heart of his appeal. He felt the Rawlsian social contract approach, that forces participants to put aside their individual and group interests and find honest answers to questions that begin with "What if everybody.....?, Would I think it fair if.....? And especially, Would I agree to.....?, would ultimately succeed in producing South Africa's only hope for a just constitution. "A use of the Rawlsian framework therefore, is the most fruitful way to proceed; what is now needed is a consideration of what justice requires in respect of the distribution of each of the primary goods." (Simkins, C. 1987. Pg 228) He quotes Rawls as saying "The principle of equal liberty requires that all citizens are to have an equal right to take part in, and to determine the outcome of the constitutional process that establishes the laws within which they are to comply. Also the constitution is to be framed so that of all the feasible just arrangements, it is the one most likely to result in a just and effective system of legislation." (Rawls, J. 1971. Pg 221)

Simkins' appeal for a Rawlsian framework for a just South African Constitution seems to have been heeded. As I have discussed in my introduction, the 1996 South African Constitution contains an extensive protection of equal rights and liberties and although it does not specifically use the term 'equality of opportunity', the concept is nevertheless implied, especially in Section 9 on "Equality." The question that I now need to consider is, what implications does this seemingly Rawlsian constitution have for health care in South Africa and how, if at all, can a health care theorist like Norman Daniels assist in its interpretation.

I have already emphasized that I believe it is imperative, when discussing HIV/AIDS in South Africa, in conjunction with health care justice, that the historical backdrop of apartheid and indeed colonialism should not be forgotten, or ignored. These issues will be seen to be particularly relevant in my discussion, because the idea of "equality of opportunity" is a central theme of Norman Daniels' approach to justice and health care.

Both colonialism and apartheid sought to entrench the opposite of "equality of opportunity" with opportunity in all forms, i.e. land ownership, freedom of movement, education,

occupation, available only to those classified under the Population Registration Act as 'White'. A succession of Acts entrenched 'inequality of opportunity' in South Africa. The 1911 Mines and Works Act, The 1923 Urban Areas Act, the 1950 Population Registration, Immorality and Group Areas Acts, the 1951 Prevention of Illegal Squatting Act, the 1953 Bantu Education Act and the 1953 Reservation of Separate Amenities Act are but some examples. (Oakes, D. Saunders, C. 1994. Pg 369) These Acts translated into huge disparities in opportunities that affected every aspect of life and living for anyone not classified 'White'. The disruption of the family unit and the entrenchment of a migrant labour system in South Africa, in particular, has had devastating effects on opportunity and well-being and has contributed greatly to the rapid spread of HIV/AIDS in South Africa.

The official disbanding of apartheid in 1994 was met with jubilation by most of the world's nations and of course by most South Africans themselves. However years of enforced racism and inequality have taken their toll on all aspects of life and in particular health care. The migration of people from the poverty stricken 'homelands' to urban areas in search of work and housing, has meant that huge squatter communities, with almost no infrastructure (water, electricity, sanitation) have burgeoned around every town and city in South Africa. Despite the population shift to urban areas, many women and children still remain in the rural areas while their men folk become part of the migrant labour system (now no longer controlled by Influx Control Laws and thus ever growing). A just health care system and especially a just approach to the HIV epidemic, in my opinion, has to be worked out within the context of this very real backdrop of 'inequality of opportunity'.

I shall now return to Daniels' adaptation of Rawls' theory of justice to health care. First it is necessary to say a few words in criticism of Greens' attempt to include health care as a primary good, even though Rawls explicitly excluded it. Rawls' list of primary goods is a restricted, but general list of "abstract properties of social arrangements." If one starts adding specifics like health or education, there comes an immediate risk of extending the list ad infinitum, i.e. to housing, food, clothing, etc. Rawls' assumption is rather that these will be provided for by fair shares of income and wealth. (Daniels, N. 1985. Pg 45)
(The intricacies of this dimension of Rawls' theory of justice are obviously way beyond the scope of my dissertation.) If all of these items i.e. health care, education, housing, etc., were in turn subject to the first principle of equal distribution then we are approaching, perhaps, nearer to Marxism or socialism and contrary to Rawls' conception of justice within a liberal social democracy with a largely free market economy.

A second problem of merely adding health care to the list of primary goods is that Rawls' 'difference principle', which requires inequalities to work to the advantage of the least well off, would result in a drain of resources into meeting the health needs of the desperately ill and disabled who have no chance of ever gaining a normal range of opportunity, perhaps to the great detriment of the rest of society. (Daniels, N. 1985. Pg 44)

Daniels adapts Rawls' theory to health care, by an alternative approach. He writes: "The most promising strategy for extending Rawls' theory, simply includes health-care institutions and practices among the basic institutions involved in providing for fair equality of opportunity. Because meeting health care needs has an important effect on the distribution of opportunity, the health-care institutions are regulated by the fair equality of opportunity principle." (Daniels N. 1985. Pg 45)

Daniels begins by asking the question:- Is health care special? Should we allow it to be viewed as a commodity to be bought and sold as a part of a free-market economy? Should we allow inequalities in the access to health care services to vary, in parallel with whatever economic irregularities arise as a result of more general principles of distributive justice (Ibid Pg 10) He believes that the question "Is health care special?, is a central one and must be answered by examining the concept of health care *needs* and differentiating between *needs* and *preferences*. He then goes on to demonstrate the moral importance of these needs by discussing their effects on *opportunity*. This process brings Daniels to the conclusion that "a general principle of justice governing the distribution of opportunity can be extended so that it governs the design and function of health care institutions and practices." (Ibid Pg 11) A theory of health care needs, according to Daniels, should explain firstly why many people do consider health care as special or different to other social goods or commodities. Secondly, this theory needs to be able to differentiate between the very important and not so important aspects of health care needs. "If we can assume (1) that there is some scarcity of health care resources and (2) that we cannot or should not rely just on market mechanisms to allocate resources, then we need such a theory to guide macro decisions about priorities among health care needs." (Ibid Pg 19) As can be seen by this statement, Daniels is dismissing a libertarian approach to health care justice as not even worth discussing. He admits these two assumptions "may draw some fire." Thus in summary a theory of health care needs must explain and justify the twin notions that health care *is* special and that some forms of health care are more special than

others. (Ibid Pg 20) In order to decide which forms of health care are more important we need to characterize relevant categories of needs that are "objectively ascribable" i.e. we can even ascribe them to someone who denies he has them., and "objectively important". At this point Daniels introduces the concept "species-typical normal functioning" and asserts that the needs that interest us, or are of fundamental importance, are those needs that contribute to species-typical functioning. (Ibid Pg 26) The reason for the importance of these needs is because of the basic fact that "impairments of normal species functioning reduces the range of opportunity open to an individual in which he may construct his plan of life or conception of the good". (Ibid Pg 27)

Daniels uses a narrow concept of health to mean absence of disease, and disease to mean "deviations from the natural functional organization of a typical member of the species". (Ibid Pg 28) Thus health care needs are those things we need in order to allow us to function normally. These include adequate nutrition and housing, safe living and working conditions, preventative, curative and rehabilitative medical services and non-medical personal and social support services. (Ibid Pg 32)

So what is important about 'normal species functioning' and why does fulfilment of health care and other needs required for normal species functioning, occupy the moral high ground? Here we reach the climax of the argument, i.e. the relationship between species typical functioning and opportunity.

> "I can now state a fact central to my approach: impairment of normal functioning through disease and disability restricts an individual's opportunity relative to that portion of the normal range his skills and talents would have made available to him, were he healthy. If an individual's fair share of the normal range is the array of life plans he may reasonably choose, given his talents and skills, then disease and disability shrinks his share, from what is fair."
>
> (Daniels, N. 1985. Pgs 33-34)

A couple of points need to be made to clarify his statement. Firstly, normal opportunity range is 'society relative' and facts about a given society need to be known to determine which diseases or disabilities result in a more serious curtailment of opportunity. Secondly, individual differences act as a 'baseline constraint' to the degree an individual can enjoy a

normal range of opportunity. Only where the differences are a result of disease or disability, not just normal variation, is it necessary to correct for these differences. Another important point that needs clarification is the fact the normal range is a general abstract range rather than an individual range. Daniels uses the example of a college teacher and a skilled labourer each finding his manual dexterity affected by a disease process e.g. rheumatic arthritis. It is important to assess the loss of normal functioning and consequent loss of opportunity against an abstract general range of normality, not against an individualized range. "We do not want to be in the business, I believe, of deciding who gets what medical services on the basis of occupation" or other 'social worth' criteria. (Ibid Pg 35)

Showing that the reason we believe meeting health care needs is important, is because the fact that ill-health affects an "individual's share of the normal opportunity range", does not automatically prove that society has an obligation to meet those needs. However, Daniels argues that if we could demonstrate that for justice to prevail, fair equality of opportunity must be protected or maintained, then we could claim that the social obligation to meet health care needs is derived from the more general requirements of justice to "guarantee fair equality of opportunity". (Ibid Pg 39) Rawls' theory of justice, as discussed in Chapter 6 gives high priority to equality of opportunity and in fact fair equality of opportunity is given lexical priority over the principle which allows for inequalities in social primary goods so long as they work to the advantage of the least well off ('the difference principle'). This means that 'fair equality of opportunity' cannot be traded for other primary goods. (Ibid Pg 40) Because health care institutions, that meet health care needs, are fundamental to the protection of equality of opportunity, Daniels believes that they should be included among Rawls' basic institutions of society that are governed by a principle of fair opportunity. Although Rawls' 'opportunity' principle was directed at jobs and careers or 'positions', Daniels believes he has shown why extending this principle to health care institutions is natural and "compatible with the reasons for wanting to protect fair equality of opportunity in the first place". (Ibid Pg 57)

In conclusion he says:-

> "What emerges is the claim that health-care institutions should have the limited, but important, task of protecting people against serious impediment to opportunity, their failing to enjoy normal species functioning. On this view, shares of the normal range will be fair, when

> positive steps have been taken, to make sure that individuals maintain normal functioning, where possible, and that there are no other discriminating impediments to their choice of life plans. Still, fair shares are not equal, since individual talents and skills will still differ, and these form a natural baseline against which individual shares of the normal range are defined.
>
> (Daniels, N. 1985. Pg 57)

A principle of justice for health care that has as its central component, a rule or principle of equality of fair opportunity seems to be particularly attractive and plausible for adoption to the current South African context. I have emphasized in my previous discussion that the majority of South Africans have been severely affected by a regime that until very recently upheld 'inequality of opportunity' as its central ideology. The legacy of this 'inequality of opportunity' continues to negatively affect many, if not most South Africans, despite the fact that apartheid has been officially disbanded. The HIV/AIDS epidemic affects mostly those very people whose opportunities have already been curtailed by years of political injustice. Just when these South Africans were at last starting to have opportunities to construct their life plans on a more equal, or even playing field, the 'goal posts' have again been shifted out of reach, this time by a disease process.

HIV/AIDS obviously markedly affects the opportunity range available to those individuals who are infected. Most individuals contract AIDS before they turn 30 years of age. After the infection they are likely to die within 10 years. The last 2-3 years of life are usually marked by increasing ill health, pain and suffering. Mothers who pass the infection on to their off-spring are likely to see their children die before their 5^{th} or 6^{th} birthday, that is, if they themselves are lucky enough to outlive them. All this represents a devastating loss of opportunity. It is within this context that I believe Daniels' plea to be entirely justifiable. "I urge the fair equality of opportunity principle as an appropriate principle to govern macro decisions about the design of our health care system. Such a principle defines, from the perspective of justice, what the moral function of the health care system must be - to help guarantee fair equality of opportunity." (Daniels, N. 1985. Pg 41)

Once this principle of fair equality of opportunity has been broadly accepted, it then becomes necessary to work out more specifically what its actual implications are. As Van der Wilt says "What constitutes the "the normal range of opportunities" for a given society

and what constitutes "individual fair shares" there of, are normative and socially negotiable judgements." (Van der Wilt, G. 1994. Pg 332). Deciding the answer to the above i.e. what constitutes the normal range of opportunity within the current South African context would be an extremely demanding and complicated task and I shall not attempt it here. However, I feel I can assume that being HIV positive and subsequently developing AIDS and dying prematurely, (within 10 years) represents a marked reduction in what the average South African would want as a "normal range of opportunity".

Rawls' contract theory portrayed those in the 'original position' as normal, fully functioning members of society. According to Daniels subsuming health care institutions under the opportunity principle, is an attempt to keep the system as close as possible to Rawls original idealization, i.e. that we are concerned with a normal, fully functioning person with a complete life span. (Daniels, N. 1985. Pg 47) In order to do this Daniels proposes four 'layers' or levels of health care:-

1. **Preventive health institutions** will attempt to prevent any deviation from normal species functioning before it has occurred This 'layer' is obviously extremely important within the context of HIV/AIDS and thus a significant part of resources should be spent on preventative measures such as :
    - education for life-style change,
    - voluntary counselling and testing services (VCT),
    - condom distribution and treatment of sexually transmitted diseases (STD's).
    - mother-to child prevention regimes and infant artificial feeding programmes
    - provision of basic infrastructure like safe drinking water and sanitation, and
    - funding of medical research into HIV vaccine development .

2. **Personal medical and rehabilitative services** that restore normal functioning. At this point in time there is no complete cure for AIDS and so in a sense it is not possible to completely restore normal functioning. However, treating opportunistic infections, especially tuberculosis, would restore near normal functioning in many cases. As the chance of successfully treating opportunistic infection and restoring near normal function becomes increasingly remote as the disease progresses, then the moral obligation to provide expensive treatment without the hope of success reduces. The question of whether or not Anti-Retroviral Treatment (ART) should be made available also, must be addressed here. I believe that the principle of fair equality of opportunity

dictates that ART most certainly should be available for most patients except perhaps those with terminal illness whose hope of successful rescue is unlikely. There is sufficient scientific medical information available to illustrate that the use of ART dramatically reduces morbidity in most cases and markedly extends life, and improves quality of life (and consequently access to opportunity). (Miller, S. et al 2002. Pg 22; Nachega, J. 2002 Pg 15; Pallela, F et al 1998) Obviously the implications of this assertion are profound in terms of resource utilization and availability. However, it is my intention here to justify a moral framework for health policy with respect to HIV/AIDS, not to work out the details of this policy. I believe that once the basic moral principles for just health care have been accepted, then the task of implementation and resource development and access can be tackled in a directed and purposeful manner. I shall discuss this in more detail in my conclusion

3. **Health Services for the chronically ill.** The nature of HIV/AIDS means that eventually most patients will become chronically ill and will not be able to return to a normal range of opportunity, but will need support and services that can assist in keeping them as near normal as possible. This third layer Daniels describes as "extended medical and social support services for the chronically ill."

4. **Support Services for the terminally ill and severely disabled.** The fourth layer of services are those for the terminally ill and severely physically disabled. At this level of service there is no chance of ever returning those affected to a point where they can have an opportunity at some share of normal functioning. Hence Daniels believes that this level of services may not in fact fall under the principle of justice we are invoking, but rather rely on other moral principles, such as beneficence. Within the context of the HIV/AIDS crisis in South Africa, I think one should argue that rather than not spending resources on care of those terminally ill (so-called Home-based and Community-based models of HIV/AIDS care would fit in here) one should instead guard against spending a great deal of available resources on care of the terminally ill and programmes for home-based care, *while simultaneously* neglecting 'level two' care. This is the level where one still has a chance of availing the HIV infected individual with at least a measure of his share of the normal range of opportunity. The current South African tendency is to focus most resources on prevention and home-based/terminal care and simply to ignore 'level two' care on the obvious grounds that it is too expensive and requires resources that are simply not available.

One area of need that is specific to HIV/AIDS is the necessity to care for orphans. If one returns to the principle of fair equality of opportunity, it can be seen that children who are orphaned by this epidemic, suffer an immeasurable loss, not least their share of a normal range of opportunity, i.e. to grow up in a nurturing, safe family environment. The allocation of resources to providing care for orphaned children, would thus be an important and major component of this conception of just health care. Various models for support and care of orphaned children have been postulated and explored, (See Schneider, H. and Russell, M. 2000. Pgs 14-17) and I shall not discuss them in any detail here.

In an article entitled "Health Care and the Principle of Fair Equality of Opportunity: A Report from the Netherlands." Van der Wilt examined three areas of health care financing that have been the subject of much public controversy and debate in the Netherlands, viz., In Vitro infertility treatments (IVF), plastic (cosmetic) surgery and liver transplants. He uses a casuistic approach to conclude that Daniels' model of just health care seems to provide a descriptive or explanatory account of common morality, i.e., "the Principle of fair equality of opportunity reveals and articulates the moral concerns underlying the debate over the public funding of health care services. Thus bringing this principle to bear on resource allocation discussions should improve our understanding of these underlying moral concerns. (Van der Wilt, G. 1994. Pgs 345-347) Public controversy in South Africa in recent years surrounding the Government's approach to health care and HIV/AIDS and its reluctance to make anti-retroviral medication available for prevention and curative measures, seems to echo these sentiments.

It is obvious from the preceding discussion that I believe Daniels' approach to justice in health care is particularly relevant for South Africa to-day. Of course the knee-jerk reaction to adopting the principle of fair equality of opportunity as a basic principle of health care institutions, is to proclaim that as wonderful as it all sounds, we as a nation could not possibly afford to embark on such a journey. If we did, we would cripple the nation, by pouring all available resources into a bottomless pit of misery and disease. I shall address this argument in my conclusion. First I must consider the implications of a libertarian theory of justice for HIV/AIDS.

Chapter 8

A Libertarian Theory of Justice.

In a liberal society, the values of personal autonomy and liberty and a "right to choose one's own way of life" are considered central. The state's primary role is to protect personal liberty and property, but has no role to play in the sphere of personal morality, i.e. there is a clear separation between matters concerning personal morality and matters concerning law. The law is not about the 'enforcement of morals' but only applied to the protection of liberty and property. (Charlesworth, M. 1993. Pg 1) Libertarianism is a term that is often used synonymously with terms such as liberalism, free market economics and the theory of the minimal state. According to Barry it has no precise meaning "except that in a general sort of way libertarianism describes a more vigorous commitment to moral and economic individualism and a more ideological approach to social affairs than conventional liberalism" (Barry, N. 1990. Pg 109) One of the central components of libertarianism, is the idea that coercion may only be used to prevent physical harm, theft and fraud, to punish those guilty of such, and to enforce contracts. (Buchanan, A. 1981. Pg 10)

Various writers in the sphere of political philosophy have expounded libertarian views, e.g. Friedrich von Hayek. However for this dissertation on libertarian justice I shall concentrate on Robert Nozick's widely recognised "Entitlement Theory of Justice" which he explicated in *Anarchy, State and Utopia* in 1974, partly in response to Rawls' 'Justice as Fairness'. As in the previous sections on 'Utilitarian Justice' and Rawls' 'Justice as Fairness' I shall first explain and summarize the main points of the theory by referring to the original text. I shall then consider various comments and criticisms and attempt to highlight this theory's strengths and weaknesses.

The essence of Nozick's theory consists of two central ideas. Firstly, individuals have rights of liberty and property. "No one ought to harm another in his life, health, liberty or possessions". (Nozick, R. 1974. Pg 10 : In a footnote quoting Locke)[1] Secondly the only legitimate role the state has to play, is in protecting individual rights of property and personal freedom, ensuring that others do not interfere in those rights and punishing those who do. Nozick introduces his book thus:-

> "Individuals have rights, and there are things no person or group may do to them (without violating their rights). So strong and far-reaching are these rights that they raise the question of what, if anything, the state and its

> officials may do. How much room do individual rights leave for the state? The nature of the state, its legitimate functions and its justifications, if any, are the central concerns of this book".
>
> (Nozick, R. 1974. Pg ix)

Nozick accepts Locke's statement of rights as given, i.e.:- "individuals have complete freedom to order their actions and dispose of their possessions and persons as they think fit, within the bounds of the law of nature, without asking leave or dependency upon the will of any other man." The bounds of law of nature I have already quoted, i.e. "no one ought to harm another in his life, health, liberty or possessions." It is important to note here that Nozick does not attempt to provide any justification for these basic 'Lockean' rights. He assumes them to be true and bases the rest of his argument, or theory, on this presumed statement of fact. (Buchanan, A. 1981. Pg 3)

After laying the foundations of his theory by a statement of rights, Nozick goes on to show how the only form of state that is justifiable, is a minimal state that does not interfere with individual rights, except to uphold them. He then proceeds to explicate the entitlement theory of distributive justice. Firstly, the term 'distributive justice' is not a neutral term and should in fact be abandoned, because it implies there is a central pool of things to be distributed, with somebody or group in control of the distribution process. This Nozick believes, is a misconception, because there is no central distribution with one person or group entitled to control resources and "jointly deciding how they are to be doled out." (Nozick, R. 1974. Pg 148) What each person gets, is received from others, either as a gift, or in exchange for something, e.g. his labour or time. "There is no more a distributing or distribution of shares, than there is a distributing of mates in a society in which persons choose when they should marry". (Ibid Pg 150) So Nozick chooses to speak about people's "holdings" and a "principle of justice in holdings", rather than "distributive justice."

The concept of "justice in holdings" covers three broad areas or "topics", each giving rise to a principle. The three principles constitute the essence of Nozick's entitlement theory of justice and he believes that anything and everything to do with property and possessions, personal input or labour should fall under the jurisdiction of these three principles which he first names and then specifies.

- The first area concerns the "original acquisition of holdings" or the "appropriation of unheld things". The principle involved here is the principle of "justice in acquisition of holdings".
- The second area or topic concerns the transfer of holdings from one person to another, hence the "principle of justice in transfer". Thus so long as one acquires a holding in accordance with the first principle and transfers it in accordance with the second principle justice is done. However, unfortunately human nature being what it is, these two principles are sometimes breached due to theft or fraud, thus a third area of discussion and principle is needed to complete the picture.
- The third area or topic is that of the "rectification of injustice in holdings", hence the "principle of justice in rectification". (Ibid Pg 152)

The next step in the explication of Nozick's theory is the specification of his three principles. The first principle is the "principle of justice in acquisition". This covers the acquisition of things, e.g. property or resources that are as yet "unheld", i.e. not owned by anybody. Is erecting a fence around a tract of land, or grazing one's cows on that land, good enough to claim it as yours? Nozick draws on Locke's Theory of Acquisition and Locke's proviso "enough and good left in common, for others", to specify his first principle. Thus the first principle comes with a proviso; "A process normally giving rise to a permanent bequestable property right in a previously unowned thing, will not do so, if the position of others no longer at liberty to use the thing, is thereby worsened". (Ibid Pg 178) Excluded from this proviso is the "worsening due to more limited opportunities to appropriate" and the worsening of a "seller's position if I appropriate material he is selling and enter into competition with him". However, if the appropriator compensates others whose condition may be worsened, by no longer being able to use the item appropriated, then the acquisition is just.

The second principle is also qualified, because if one appropriates some of a certain substance, but then obtains the rest by purchasing it from others one may still violate the Lockean proviso for acquisition if, for instance one secretly approached all the holders for their share, without divulging the fact that one was trying to secure a complete monopoly. "Each owner's title to his holdings includes the historical shadow of the Lockean proviso on appropriation". Nozick uses an example of someone in a desert who owns a water hole. He may not charge what he likes if his is the only water hole for miles around. Likewise he may not charge, if all his neighbours' water holes dry up and his doesn't. But if his water

hole does not dry up, because of some action he took to protect it, or prevent it from drying up, that his neighbours did not take, then he can justifiably charge for the use of the water. This theory does not say that owners do not have rights, but rather that these rights can be overridden in a catastrophe. (Ibid Pg 180)

Finally, one must consider the third principle, of "justice in rectification". If injustices appear to have occurred because of a breach of one or both of the first two principles, then the third principle must be invoked. A historical and partly empirical investigation must occur to determine the facts about previous situations and injustices done in them, as defined by the first two principles. If after all the facts have been considered it becomes apparent that holdings would be different to what they are currently, if the relevant principles had been properly adhered to, then a rectification must occur. Implications of this third principle could be quite far reaching and even Nozick is unsure of exactly how they would be adequately established. He makes this clear in the following statement:-

> "If past injustice has shaped present holdings in various ways, some identifiable and some not, what now, if anything, ought to be done to rectify these injustices? What obligations do the performers of justice have towards those whose position is worse than it would have been had compensation been paid properly? How, if at all, do things change if the beneficiaries and those made worse off are not the direct parties in the act of injustice, but, for example their dependents? Is an injustice done to someone whose holding was itself based upon unrectified injustice? How far back must one go in wiping clear the historical state of injustices? What may victims of injustice permissibly do in order to rectify the injustices being done to them, including the many injustices done by persons acting through their government? I do not know of a thorough or theoretically sophisticated treatment of such issues."
>
> (Nozick, R. 1974. Pg 152)

These are deep and probing questions indeed. They will have to be considered in more detail in the next chapter, where I discuss the application of Nozick's theory to the South African situation. Such questions are, in this context, of particular pertinence.

These three principles, now specified, constitute the entitlement theory of justice. All other principles or theories of justice result in what Nozick calls 'patterned distributions'. The distribution follows a pattern for instance, to each according to merit, need, IQ, etc. The entitlement theory is not patterned because there are no specific criteria that yield particular distributions. The set of holdings that result when the principles of entitlement are operating justly, is random and results from any number of acquisitions and transfers, e.g. gambling wins, interest from shares, gifts, in exchange for labour, bequests, etc. There is no pattern involved. There may be strands of patterns running through the distributions but no one pattern that describes the entire distribution. (Ibid Pgs 156-157) Nozick then asks whether people will tolerate a system that yields distributions that are unpatterned? He believes they will, because in a capitalist society, people transfer holdings often to others in accordance with how much they perceive they are benefiting from those others, although sometimes there may be other valid reasons, like duty or charity. The point is that these transfers are "largely reasonable and intelligible". "The system of entitlements is defensible when constituted by the individual aims of individual transactions. No overarching aim is needed, no distributive pattern is required." (Ibid Pg 159)

Another point that Nozick makes is that pattern theories of distributive justice separate production from distribution and treat them as two unrelated entities which he regards as absurd. "The situation is not of something getting made and there being an open question as to who is to get it. Things come into the world already attached to people having entitlements over them." (ibid Pg 160) The entitlement theory of justice treats production and distribution as one entity. If one wishes to express this theory in the traditional form of 'to each according to ------, from each according to -------' then Nozick believes the closest would be:-

From each as they choose, to each as they are chosen."!

The bottom line in Nozick's view, is the fact that no "patterned system of distributive justice can be continuously realized, without continuous interference in peoples lives." (Ibid Pg 163) Of course the implication is that this interference is unjust and unjustified and he goes on to state quite baldly "Taxation of earnings from labour is on a par with forced labour". (Ibid Pg 169)

Nozick continues his discussions by illuminating his views on matters such as 'equality', 'equality of opportunity' and 'philanthropy'. He declares that it can not be assumed that equality must be built into justice. (Ibid Pg 233) Provided that a particular distribution arose from a legitimate process, then the fact that the wealthy x% of the population control 10x of the wealth and the poor y % control 1/10 y of the wealth, is irrelevant and can only be altered if an individual chooses to transfer some of his holdings voluntarily to others in order to make the situation more equal. Anything else amounts to forced labour or coercion. He illustrates his point with an argument put forward by Bernard Williams in an Essay entitled "The idea of Equality."[2] Williams argues that the proper grounds for distributing medical care is ill health, i.e., medical needs. This he says "is a necessary truth". When services are only available to those that can pay for them, (as in Nozick's scheme), then one has a situation of inequality between the 'poor ill' and the 'rich ill' whose needs are the same, but do not receive the same treatment. This situation, Williams believes, is irrational. However, Nozick strongly disagrees. He says Williams is arguing that if an activity (e.g. the practice of medicine) has an internal goal, i.e. the healing of the sick, then the only justifiable ground for distributing that activity is on the basis of need. Those who need most healing should receive most care. Thus a barber should always cut the longest hair first and a gardener should attend to the lawn that needs it most. Of course we have no problem accepting that the barber and the gardener should offer their services to those who can pay for them. Why should a doctor be any different? "Why must his activities be allocated via the internal goal of medical care? It seems clear that he needn't do that; just because he has this skill, why should he bear the costs of the desired allocation, why is he less entitled to pursue his own goals, within the special circumstances of practicing medicine, than anyone else?" (Ibid Pg 234) Presumably, says Nozick because medical care is important and people need it extensively, but so is food important. Farmers can produce it and transfer it according to free market exchange without this being questioned. Williams, according to Nozick ignores the question of where things or actions (services) to be allocated, come from and the fact that they do come "already tied to people who have entitlements over them." (Ibid Pg 235)

Equality of opportunity can be achieved by two methods: making the situation of those with greater opportunity worse or improving the situation of those with less opportunity. To achieve the latter one needs resources and these must be taken from others, thereby also worsening their situation. However, holdings to which people are entitled may not (according to Nozick's plan) be removed even to provide equality of opportunity to the less

fortunate. Thus "in the absence of magic wands" the only way of achieving any form of equality of opportunity is to convince people to voluntarily allocate some of their holdings to achieve it. (Ibid Pg 235) Similarly philanthropy is acceptable and laudable but can only ever be voluntary, never compulsory. (Ibid Pg 265-268)

In summary then, the essential components of libertarian social theory and a libertarian theory of justice are that individuals have unquestionable rights to personal liberty and property and may do what they choose, provided that they do not interfere with, or harm in any way, other members of society, who all hold the same rights. The only role of the state should be to uphold and where necessary enforce these rights. Coercion may be used only to prevent physical harm, theft or fraud and to punish perpetrators of the same and to enforce contracts. (Buchanan, A. 1981. Pg 10) A libertarian theory of justice, best articulated by Nozick, states that the distribution of holdings are governed by the principles of justice of acquisition, justice in transfer and justice in rectification. Patterned or end-state distributions, (each according to x), are by their very nature unjust because they all involve the coercive transfer of someone's holdings to another without their permission.

It is apparent from the previous discussion that the libertarian theory of justice is fairly compatible with a western style liberal democracy and a free market, capitalist economy. Nevertheless many members of a liberal democracy are uncomfortable with the radical implications of Nozick's scheme, if it were carried out to completion. Even the most ardent supporters of liberal democratic ideals, acknowledge that the shadow of past unjust acquisitions and transfers, may have a very long reach and that the circumstances of those who struggle to adequately purchase their health care requirements, may not in fact be entirely of their own making or misfortune. The libertarian assertion that those in dire medical need, who cannot afford treatment, may only hope for charity and then be grateful if some comes their way, having no right to anything they cannot access by a process of fair exchange (i.e. pay for) is for this reason in particular, difficult to wholeheartedly embrace.

Nozick's theory has been criticized on several accounts, not least that mentioned above. I shall now briefly consider some of the other criticisms levelled at Nozick. One of the first criticisms that Nozick must face is the fact that he gives no justification for the 'rights' that his theory is based on, but merely accepts them as fact. Day points out that Nozick criticizes Williams when he claims that it is an indisputable moral premise that medical

services should be allocated on the basis of need. But, "On what grounds are Nozick's 'rights' on stronger moral ground than William's 'needs'?" (Day, J. 1990. Pg 45)

Nozick has also been criticized for his interpretation of Kant's maxim that persons should not be used only as 'means', but always as 'ends'. Nozick uses this maxim to support his assertion that taxing the rich to aid the poor is unjust and a violation of Kant's principle. However, Kant's principle is ambiguous in that he talks about not using someone *only* or exclusively as a means to an end. Rawls, who also draws heavily on Kant, does not rule out the state taking from the rich to improve the prospects of the least advantaged. The rationale for this is that although redistributing some of the wealth of the rich is using them as 'means', they can still be treated as 'ends' because their basic interests are protected by Rawls' first principle. The crucial question is what does it mean to treat a person *only* as a means to others' ends? How can we determine what can be taken from an individual without that person being used exclusively for someone else's benefit? Kant's principle does not say that persons must never be used as a means to others' ends, just not exclusively, i.e., we must treat them as 'ends' as well. Nozick's interpretation seems to be that persons may never be used as means. This seems to be a somewhat loose interpretation of Kant's maxim.
(Day, J. 1990. Pgs 45-46)

Nozick's theory is also strongly criticized by communitarians. From a libertarian point of view it is the experiences of individuals that have intrinsic value. "There are no objective states of affairs that can be understood or appraised independently of the effect that they have on individual attitudes, feelings and emotions. A common culture, an artistic tradition or a traditional way of life, have no intrinsic value, though each may have considerable instrumental value in promoting that which is of intrinsic value, individual experiences." (Barry, N. 1989. Pg 11) Communitarians dispute this. They believe the individual is constituted in part at least, by his social relations and historical-cultural tradition, and that the moral aim of libertarians to reduce coercion to the minimum needed to uphold individual rights means that minor interventions "the rationale of which lies in the preservation of an intrinsically valuable cultural inheritance", are precluded. (Ibid)

Another problem with Nozick's theory is that one could ask, what precisely, are the foundations of the entitlement theory of justice? The way in which we come to own property is as much a matter of human convention, as a universal moral principle. In some

societies all the land belongs to the community and no way is recognized whereby an individual can establish property rights over previously owned land. This seems to imply that the exact content of the entitlement theory of justice in any particular society depends on the traditions and decisions within this society. Hence a society could theoretically change its convention as to what constitutes the legitimate acquisition of holdings, to include some notion, or principle, of redistribution, such as need. (Day, J. 1990. Pg 50)

The above conception is presented by Brody, as a "quasi-libertarian theory of justice". He proposes that there exists simultaneously a right to property and a right to redistributive welfare, because of the difference between "labour-related (or added) wealth and the wealth which is the value of natural resources." His theory is an attempt to rectify the perceived callousness of Nozick's libertarianism and is presented as a type of social contract theory where people in a society agree to:-

- allow for the formation of exclusive property rights over natural resources as well as added labour-created values,
- compensate those who would lose the rights to use the natural resources assigned to property values, and
- provide that compensation in the form of socially recognized welfare rights, i.e. socially recognized rights to a minimal level of support." (Brody, B. 1981. Pg 156)

In conclusion, libertarianism and in particular, Nozick's conception of it, means that no one, no matter how great their need, has a right to health care unless they can purchase it or exchange some form of property or service for the desired or needed health care.

The implications for this conception of justice for health care policy, shall be the subject of the next chapter.

Notes

1. John Locke (1632-1704) published *Treatises of Government* (1690) and *Essay Concerning Human Understanding* (1690). Nozick is referring to *The Second Treatise* in which Locke develops his account of individual rights and political authority.
2. Nozick is referring to Bernard William's essay "The Idea of equality" in Peter Laslett and W.G. Runciman. Eds *Philosophy, Politics and Society* 2nd series. Oxford: Basil Blackwell, 1962.

Chapter 9

Libertarian Justice and the HIV/AIDS Epidemic in South Africa.

A strictly libertarian approach to health care is quite simple -- "To each according to his ability to pay." Health care becomes a commodity like any other and must be bought or sold under a system of fair exchanges. The question that immediately springs to mind is Daniels' question; 'Is health care special?' Should health care really be treated as a commodity or does it fall into a special category of social goods that must be considered outside of Nozick's principles of entitlement? In this discussion I shall first consider the question, is health care a commodity, and discuss the implications for health care in general, if it is entirely subsumed under Nozick's entitlement theory of justice, i.e. regarded as a commodity. I shall then discuss a libertarian approach to justice in health care with particular reference to current-day South Africa and the HIV/AIDS epidemic.

The libertarian answer to the question, should health care be regarded as a commodity governed by the principle of a market-based economy, is a resounding yes. This assertion has been adequately explicated in the previous chapter. However, this view is vociferously contradicted by many bioethicists, medical practitioners and even politicians. The well-known ethicist Edmund Pellegrino writing on this subject, states in a most forthright manner that :-

"Health and medical care are not, cannot be and should not be commodities; the ethical consequences of commodification are ethically unsustainable and deleterious to patients, physicians, and society; commodification does not fulfil its economic promises and health care is a universal human need and a common good, that a society should provide in some measure, to its citizens." (Pellegrino, E. 1999. Pg 244) Writing in a similar vein, Cathleen Kaveny says "The time has come to step back and look at the broader ramifications of a societal decision to intertwine medicine and the market. Worries about these ramifications are frequently articulated as generalized fears about a world in which health care has been turned from a personal service into a commodity." (Kaveny, C. 1999. Pg 208)

A closer look at 'health care' and all it encompasses does seem to demonstrate that 'health care' as an entity, has many features that cannot be easily accommodated by the concept 'commodity' and in turn by market theory. A commodity is a 'thing' or a 'service'

that can be bought or sold. Its worth can be represented in its totality by a monetary value. The price of a commodity, in a pure market, is not determined by an intrinsic assessment of its worth, but rather by how much that commodity is in demand. Commodities are fungible, i.e. like exchanged for like. The value of a commodity is instrumental and determined by how much it satisfies the desire of its owner. (Kaveny, C. 1999. Pg 210) The system for distributing commodities is the 'market' and as the most important feature of a commodity is its price, the market adopts a price-centred system of distribution, i.e., first to pay, first to receive. In any given transaction those involved are autonomous agents who interact only as 'buyer' and 'seller'. The transaction is designed to facilitate the relationship between subject and desired object, i.e. buyer to commodity and seller to money involved. (Ibid Pg 212) The relationship between the buyer and seller is non-existent, except as a conduit for the transaction. In summary a market economy represents the allocation of goods by a price mechanism. "Prices ration -- those unable to pay do not get the commodity; prices indicate scarcity -- the more the demand and the less the supply the higher the price; prices direct resources in the direction of demand -- the higher the price for a specific commodity the more profitable it is to produce it." (Heubel, F. 2000. Pg 243)

After ascertaining the nature of a commodity we are now able to look at the nature of health care. Health care can be considered a multidimensional good, that involves a range of medical interventions aimed at achieving three particular functions. First health care is aimed at increasing the health of the population in general (public health care) by education, vaccination programs etc. Medical research and education can also be considered here. This form of health care is a 'public good' that affects all members of society. Secondly, health care must improve the health status of the individual, by providing personal health care services and interventions. Thirdly, health care must offer support to those who will never be returned to full health, i.e. the terminally ill, frail elderly and physically and mentally disabled. (Kaveny, C. 1999. Pg 213) If this is what 'health care' as we commonly understand and accept it entails, then what are the implications for society, if health care is regarded purely as a commodity, to be bought and sold in an open market? Personal medical services can and are increasingly comodified in many societies, to the benefit of those who can pay for them and to the obvious detriment of those who can't. How, one must speculate, would the 'market' address the first and third areas or functions of 'health care'. I think the obvious answer is that there is no place, or only a

limited place in a pure market economy for the adequate distribution of these functions of 'health care'.

Heubel argues that the nature of health care services is such that they fall in the gap between commodities on one side and the persons or agents (buyers and sellers) on the other and hence can not be fitted into market theory adequately. The fact that the consumer (patient) must depend on the seller (physician) to understand the nature and necessity of the service and indeed to enable him to chose which service he must 'buy', is already a distortion of market theory. The physician (seller-agent) is in a double role because, as participants in a market they must pursue their own interests, but as partners in a relationship they should follow the patient's interests. (Heubel, F. 2000. Pg 244) In many respects this appears no different to any other service transaction where professional codes of conduct dictate that the clients interests must always be protected. However similar transactions usually involve a neutral third component e.g. an insurance policy, bank service or even a new hairstyle. As an example, if I wish to have my car repaired by a service provider, and discover it can't be repaired, then it can be replaced. In the health service however, the fact that the service pertains to the buyer personally, invokes a completely different dimension to the transaction. I cannot exchange my body for a new one.(Ibid Pg 245) The transaction between a health care provider and a client (patient) does not involve a third 'subject'. The client purchasing the service is the subject of the service and often this involves the client exposing himself, both literally and figuratively, in a manner that is undignified, humiliating, sometimes frightening and frequently a demonstration of human vulnerability at its most pathetic. Often, for the transaction to be entirely satisfactory, especially from the view point of the client-patient, many complex factors that are difficult to quantify, need to be present, like trust, compassion, empathy and fidelity. Economic market theory assumes that the participants in the market, on both sides of the transaction, are roughly equal, can negotiate a fair price and walk away from the transaction if dissatisfied. However, in a health care service transaction this is often not the case, as the relationship between the 'buyer- patient' and 'seller-physician' is highly complex and complicated and often uneven. Attempting to fit this relationship, as just described into a pure market transaction, can thus be difficult and unsatisfactory from the perspective of both parties.

For Edmund Pellegrino the 'heart' of the enterprise called medical practice, or health care, is "the quality and nature of the personal relationships involved." And this is the central reason in his opinion, why a market approach to health care is completely inadequate.

> "By 'health care' therefore, I mean the provision of assistance to persons in need of care, cure, education, prevention or help, related to trauma, illness, disease, disability or dysfunction, by other persons knowledgeable and skilful in providing such assistance. The central feature of health care is the personal relationship between a health professional and a person seeking help. Commodities may be used in the process of providing care, but the totality of health care itself is not a commodity. "
>
> (Pellegrino, E. 1999. Pg 247)

Thus if health care can not be equated with the concept of a commodity, then a libertarian theory of justice that does just that, is immediately questionable.

A slightly different perspective is provided by H. Tristram Engelhardt, Sr. He argues that debates around the allocation or distribution of health care, centre around the question of how one views the natural lottery. If one sees the outcomes of the natural lottery as morally neutral, i.e. unfortunate but not unfair, then this will influence one's viewpoint on health care distribution. A society who holds this view, may be deemed unfeeling or lacking in benevolence, if the health care needs of the unfortunate are not met, but not unjust. Engelhardt quotes Leviticus 19:15. "Do not pervert justice by giving false awards, whether by taking a man's poverty into account, or by flattering the great; give every man his just value". The difference between John Rawls and Robert Nozick is, according to Engelhardt, the difference in the way they believe; "we should see ourselves in the likeness and image of God" and assume his perspective. John Rawls' participants in the 'original position' are like "demigods" who decide that the natural lottery is unjust and should be corrected. Nozickians on the other hand, interpret the natural lottery as morally neutral. This means that society has no moral obligation on the grounds of justice to correct or compensate or even assist those adversely affected. (Engelhardt, H.T. 1981. Pg 127) The much weaker obligation of beneficence or charity, may require some action, but not justice.

Moffit believes that personal freedom and responsibility should be at the core of health policy and are best articulated by a free market health policy. He advocates an entirely market-driven health care system operating on the market-economy basis of supply and demand, where costs are not hidden in government or managed health care bureaucracies. However, Moffit fails to address any of the problems we have discussed regarding the suitability of the health care enterprise to free market economics. Nor does he address the problems of access to health care for the poor and indigent. (Moffit, R. 1994. Pg 471-481)

Apart from the general problems we have discussed regarding applying a libertarian system of justice, (essentially a free market based system) to health care, we now need to turn our attention to the current South African situation specifically. The fact that an estimated 25% of the South African population is unemployed means that if health care were only available to those who could afford it, a large proportion of the population would have no access to health care at all and death rates, especially from HIV related infectious diseases like Tuberculosis, would rapidly increase. Links between poverty and AIDS are established with a higher prevalence of HIV in very poor households.(Tush, M. 1999. Pg 12) The consequences then of a libertarian approach to health for the HIV/AIDS affected sector of the population, would be dramatic and devastating, especially if libertarianism is interpreted as "to each according to his ability to pay."

However, it is important to remember that a libertarian theory of justice as articulated by Nozick incorporates a third dimension namely "the principle of rectification for past injustices". How would this principle 'play out' in South Africa? What would be the consequences and ramifications of attempting to apply Nozick's third principle to post-apartheid South Africa? This principle is a vital component of Nozick's concept of libertarian justice. Without it, justice is no longer just. The entire scheme becomes invalid. The principle of rectification requires the use of

> " ..historical information about previous situations and injustices done in them (as defined by the first two principles of justice and rights against interference), and information about the actual course of events that flowed from these injuries, until the present and it yields a description (or descriptions) of holdings in the society..... If the actual description of holdings turns out not to be one of the descriptions yielded by the

principles, then one of the descriptions yielded, must be realized." (i.e. a correction or rectification must occur.)

(Nozick, R. 1974. Pgs 152-153)

Recent 'land reform' in Zimbabwe and the apparent lack of progress in land reform in South Africa, bears testimony to just how complicated and how profound the implications of Nozick's third principle really are. To adopt a libertarian stance on matters of distributive justice like health care, but neglect the third principle especially within the context of post-colonial/post-apartheid South Africa, must be to perpetuate and indeed perpetrate an injustice.

Adequately addressing the HIV/AIDS crisis in South Africa must involve a massive public health education initiative. This is currently being sponsored in part by the American philanthropic organization, The Henry J Kaiser Foundation in the form of 'The Love Life' youth campaign. It seems unlikely that a market-based health policy would have any incentive to undertake a similar initiative mainly because there is no profit (and potentially a large financial loss) in such a project. Privatization of health, care shifts the focus of attention from "How can people prevent illness?" to "How can they pay for treatment? " (Tush, M. 1999. Pg 3) Similarly the training of health care professionals equipped to care for those affected by this epidemic is unlikely to be forth coming from a pure market-based health care system.

The HIV/AIDS epidemic poses huge problems to medical science. The answers to these problems must be sought by way of innovative scientific and epidemiological research. Some of this research may well be compatible with the generation of profit, e.g. for Anti-Retroviral drugs, but much of it will not, especially epidemiological research and research on '3rd world' conditions like TB and Malaria that have been adversely affected by the HIV epidemic. (Callahan, D. 1999. Pg 233)

I have examined the application of a libertarian theory of justice to health care, by utilizing a fairly narrow and radical (all encompassing) libertarian perspective. In reality, even in overtly libertarian systems like the United States, a pure form of libertarian health care does not exist, but rather runs parallel to some form of government public health system, e.g. Medicare and Medicaid in the United States. However, it is not my aim or intention here to attempt to work out the intricacies of a viable health care system, e.g. by exploring

so-called two-tiered systems. I am concerned rather with attempting to establish whether or not a broad libertarian theory of justice can provide a basic framework for a just health care policy in South Africa. I believe that I have provided sufficient justification for my claim that a libertarian theory of justice can not , and should not, be used as a general framework for just health care in South Africa. This assertion is detailed on a more practical level by Meredeth Tush in her book *Privatizing Health Services in Africa* .(1999) She examines in detail the detrimental effect privatization has had on health services in Africa where 40% of the world's most poor dwell. Her observations ("as a U.N. Staffer") of the changes in health care systems of sub-Saharan Africa, over the last decade, under the influence of Western-based economic theory, have led her to conclude that the 'for-profit sector' is an inappropriate means of health service delivery for the populations of Africa. (Tush, M. 1999. Pg xi) In particular she focuses on the lack of incentive for the private sphere to address public health issues like safe water and sanitation or ignorance, so often at the heart of health needs in Africa.

In conclusion, a libertarian theory of justice is in my opinion, inappropriate as a general framework for a just health care policy for South Africa. However, if the complexities of Nozick's version of libertarianism, which includes a principle of rectification for past injustices, could be adequately explicated and implemented then perhaps libertarianism may have some relevance. However this formidable task would require so much empirical historical research and no doubt get embroiled in so much controversy, that the HIV/AIDS epidemic would have already resulted in devastating morbidity and mortality, before the rectification of past injustices could ever be satisfactorily resolved. Nevertheless the problems of fitting the enterprise of health care practice, that has at its core the professional, but often intimate, relationship between health care giver and patient, into a market based health care theory, would still remain unresolved.

Conclusion

My task in this dissertation has been to examine and compare three theories of justice and their implications for health care policy, within the context of the South African HIV/AIDS epidemic. In order to do this, I have made the basic assumption that health care is a matter of justice, not merely economics or charity. I have supported this assumption by situating health care within a dual framework of previous apartheid injustice and inequality on the one hand, and an egalitarian constitution, that protects a wide range of rights and liberties, on the other hand. As I have repeatedly stressed, I believe a just framework for health care policy in South Africa cannot be worked out independently from the historical context in which this problem is situated.

Do these theories of justice provide any help in structuring a health care framework that particularly addresses the HIV/AIDS epidemic in South Africa? I believe they do, although the problems posed by bioethics and health care, in particular are "among the most difficult and pressing issues with which a theory of justice must cope." They also provide answers that are often ambiguous. (Buchanan, A 1981. Pg 4) But before I discuss these 'answers' in any detail I think it is important to briefly discuss the current health care structure in South Africa

The South African Health Care System is a two-tiered or dual system. The State provides health care to all those who are not on 'Medical Aid', i.e., private, usually employer based, health insurance and who fall below a certain income bracket. This is funded by income tax. These public health care facilities are divided into primary, secondary and tertiary facilities, each with an increasing level of sophistication. A patient can usually access the system only at the primary health care level and then will be referred up the system if necessary, at the discretion of the service providers concerned. Tertiary institutions are situated only in the large centres and are usually academic hospitals. Many health facilities such as clinics, especially in rural areas, are staffed by nursing personnel, with occasional visits by doctors. The quality and level of health care offered, varies hugely, depending on area and province. Often only rudimentary services are available, especially in rural areas. The State is also responsible for public heath care such as health care education and vaccination programs, and treatment of TB and sexually transmitted diseases.

The other arm of the health care system in South Africa, is private medicine, which operates on a 'fee for service' or medical scheme basis. Medical schemes accounted for approximately 80% of the total private sector health expenditure in South Africa in 1998. About 2.28 million South Africans were members of medical schemes in 1999, about 5% of the overall population (Rama, P. McLeod, H. 2001) Of the remainder of the population, about 80% use public health facilities and the rest make use of private health care on a fee for service basis. (Dept of Health Ante Natal HIV/Syphilis sero-prevalence Survey 2000 Pg4) More than 50% of South African health care spending is done by the private sector, yet the public sector cares for 80% of the population. Treatment Action Campaign (TAC) Media Release. 2002. 10. 1)

Thus the reality of the current situation is that the vast majority of South Africans and certainly HIV positive South Africans, rely on the State for health care. I have argued in Chapter 5, that I believe a utilitarian ethic underlies many of the Government's health care policy decisions and shall not repeat those arguments now. I also believe that the whole concept of justice is quite often displaced in health care policy decisions, by pure economic considerations and calculations. This results in certain conclusions being drawn and policies being made, which many in the medical profession and civil society regard with dismay. I am of course referring mainly to the Government's reluctant MTCT program and the non-availability of Anti-Retroviral medication in state run health care institutions.

In Chapter 9 I have explained why a libertarian theory of justice, that affords no rights to health care, except to that for which one can pay, is also an inappropriate framework for an overall health care policy for South Africa. I do not deny that in a liberal democracy, freedom of choice and autonomy are precious values and thus would not exclude a private health care system for those who want it and can pay for it. However, my concern here is to find a just framework for health care for the vast majority of unemployed (19% in the Western Cape ranging up to 41% in the Northern Province and the Eastern Cape) and low income group South Africans (Abt. Association. 2000. Pg 12)

Finally in Chapter 7, I have argued that Norman Daniel's adaptation of Rawls' theory of justice, for health care could be a suitable model for just health care in South Africa. I believe that using a principle of *equality of fair opportunity* as a basic principle for health care institutions, will help in part to compensate for the injustices of the past that have contributed to the current health care crisis. Being HIV positive limits an individual's access

to a fair share of the range of normal opportunity available to him for working out his life plan in society, a range that may already have been limited as a consequence of apartheid. A health care institution or service that seeks to protect the individual's range of equality of opportunity, would thus be a positive move in the direction of just health care.

A theory of justice provides a broad non-specific framework for the development of a just health care system. Obviously, more specific principles need to be developed in order to facilitate implementation. Norman Daniels and Dan Brock developed a set of "design principles" in 1994 and these were incorporated into "Clinton's Ethics Working Groups for health reform" proposals, in the United States. I shall briefly list them here without any elaboration. (See Daniels, N. 1994. Pgs 425-433)

- "Health care is of fundamental moral importance because it protects the opportunities open to us to pursue goals in life, reduces our pain and suffering, prevents premature loss of life and gives us information we need to plan our lives".
- Universal access; Comprehensive benefits; Fair burdens
- Efficient management; Effective treatment; Quality care
- Individual choice; Personal responsibility
- Professional integrity; Fair procedures

Subsequently, Daniels, Light and Caplan have modified and further specified these principles and presented them in the book referred to previously, *Benchmarks of Fairness for Health Reform* 1996. Alan Buchanan in an article entitled *Privatization and Just Health Care*, 1995, also proposed a similar set of principles which are summarized by Benatar as:-

- "Universal access,
- access to an adequate level of care,
- access without excessive burdens,
- fair distribution of the financial costs of ensuring universal access to adequate care,
- fair distribution of the burdens of rationing care,
- capacity of improvement towards a more just system,
- education and training of appropriate numbers and types of health care providers,
- effective pursuit of high quality biomedical research, and

- cost effective use of results of biomedical research.

(Buchanan, A. 1995. Pgs 220-239; Benatar, S. R. 1996. Pgs 1567-1568) As can be seen, both of these lists of principles, are compatible with Daniels' interpretation of Rawls' 'Justice as Fairness', for health care.

Obviously, as I stated at the end of Chapter 7, the cost and resource implications of the implementation of a health care service, as described by these principles, appears to be daunting and many no doubt would assert, completely impractical. However, I believe that if such a framework for just health care were to be adopted whole-heartedly in principle, much could be done to address resource problems. These could then be tackled in a directed, purposeful and innovative manner.

It is not my purpose here to explore the intricacies of health care policy and funding, but I shall briefly mention some 'avenues' that could be explored:-

- Reallocation of the overall budget, by reviewing military expenditure dramatically. The emerging HIV crisis is considered by many, as a 'state of emergency' and one feels that first-world nations involved in contracts with South Africa, would not really have a moral leg to stand on, if South Africa reneged on some of its contracts because of the HIV crisis.

- The introduction of specific 'Red Ribbon' taxes on, for example, luxury goods and ultra-expensive motor cars.

- Efficient utilization of the billions of Rands raised by the State Lottery. Much of this money seems to be lying idle, or entangled in red tape.

- Donor funding: Relying predominately on external donor funding, to address the HIV/AIDS crisis would be unwise. South African health care could become a 'puppet on a string', controlled by first world donor bureaucracies. However to turn down offers of help, in the midst of such a crisis, is also foolhardy. The recent debacle regarding an R800 million donation by the Global Fund for AIDS, to KwaZulu-Natal is a case in point. This money was intercepted by central government, which declared that the wrong procedures had been followed by the

Kwa Zulu Natal Heath Department who applied for the grant, seemingly with out central government permission!". The money has still not been released by the Global Fund and this dispute remains unresolved despite the fact that KwaZulu Natal is a province severely affected by this epidemic with more than 30% 0f the adult population now HIV Positive (See South African Medical Journal. Nov. 2002 Vol 9. Pgs 848-849).

- Access to pharmaceuticals by donation of drugs, price discounts or compulsory licensing to "bypass patent protection and permit production of generic versions of HIV/AIDS drugs". The latter proposal is vociferously argued for by Schuklenk and Ashcroft (Scuklenk, U. Aschcroft, R. 2002. Pgs 179-195) on the grounds that this crisis represents a national emergency, which they say, according to the World Trade Organization's TRIPS regulations, allows states to compulsorily license the production of patented goods in such circumstances.

- If scarcity of resources still requires some form of rationing of treatment, then a proposal made by Landman and Henley while discussing rationing within the context of paediatric health care, should be considered. "We propose a basic moral and public policy commitment to non-abandonment: as far as possible, on a macro level; no category of vital health care need, including highly specialized or costly health care should be excluded from (some) public funding. (Landman, W. Henley, L. 2000. Pg 43) Thus if some form of rationing must be implemented, e.g. a queuing system for a specific intervention like. an ART programme, this is far better than excluding that service completely from available health services.

In conclusion then I would like to propose that the first step in addressing the health care needs of those affected by this devastating epidemic is to whole-heartedly endorse a just framework for health care. That just framework should be founded on the broad principle of 'Fair Equality of Opportunity.' If this step were taken by current-day South African policy makers, a ray of light may still shine through the "dark cloud that is obscuring the sun."

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